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Home Health Agency Services

Material Incorporated by Reference

Home Health Services Manual
(November 1993 edition) -clean

Map-248 Home Health Program
(Revised December 2001) -clean

Technical Criteria for Reviewing Ancillary Services for Adults
(February 2000 edition) -clean

Technical Criteria for Reviewing Ancillary Services for Pediatrics
(April 2000 edition) -clean

Map-248 Home Health Program
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CLEAN

MANUAL

Kentucky Medicaid Program
Home Health Benefits
Policies and Procedures

HOME HEALTH SERVICES MANUAL

Kentucky Medicaid Program
Home Health Benefits
Policies and Procedures

Cabinet for Human Resources
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

KENTUCKY MEDICAID PROGRAM

HOME HEALTH BENEFITS

POLICIES AND PROCEDURES

Cabinet for Human Resources
Department for Medicaid Services
Frankfort, KY 40621

HOME HEALTH SERVICES
USER'S MANUAL
UPDATE LOG

The purpose of this log is to provide a record of changes, additions, and deletions in the User's Manual. As sequentially numbered changes are received and posted in the User's Manual, entry of the change number in the log is expected to provide the user with a mechanism for eliminating errors and omissions.

TRANSMITTAL NUMBER	DATE	(Initials)		TRANSMITTAL NUMBER	DATE	(Initials)

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HOME HEALTH SERVICES APPENDIX

SECTION I - INTRODUCTION

I. INTRODUCTION

This new edition of the Kentucky Medicaid Program Home Health Services Manual has been formulated with the intention of providing you, the provider, with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, 275 E. Main Street, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Program Services, Department for Medicaid Services, Cabinet for Human Resources, 275 E. Main Street, Frankfort, Kentucky 40621, or Phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P.O. Box 2009, Frankfort, KY 40602, or Phone (800) 756-7557 (In-State) or (502) 227-2525.

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) began providing fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

SECTION II - KENTUCKY MEDICAID

II. KENTUCKY MEDICAID PROGRAM

A. General Information

The Kentucky Medicaid Program, is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U.S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services rendered to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medicaid Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Department for Medicaid Services is bound by both Federal and State statutes and regulations governing the administration of the State Plan. The Department shall not reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered unallowable medical services.

The Kentucky Medicaid Program, Title XIX, Medicaid, is not to be confused with Medicare. Medicare is a Federal provision, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. The coverage, either by Medicare or Medicaid, will be specified in the body of this manual.

B. Administrative Structure

The Department for Medicaid Services, within the Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. The Department for Medicaid Services makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been rendered to eligible recipients.

Determination of the eligibility status of individuals and families for Medicaid benefits is a responsibility of the local Department for Social Insurance Offices, located in each county of the state.

C. Advisory Council

The Kentucky Medicaid Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of eighteen (18) members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining seventeen (17) members are appointed by the Governor to four-year terms. Ten (10) members represent the various professional groups providing services to Program recipients, and are appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three (3) months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five (5) or six (6) member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is decided by the professional organization the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medicaid Program is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulates that Title XIX Program have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medicaid Program has secondary liability. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services rendered. If you, as the provider, should receive payment from Medicaid before knowing of the third party's liability, a refund of that payment amount shall be made to Medicaid as the amount payable by the Department shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap or age.

SECTION II - KENTUCKY MEDICAID

Each medical professional is given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his medical care.

When the Department make payment for a covered services and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and/or imprisonment.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

All recipients of this Program are entitled to the same level of confidentiality accorded patients NOT eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical speciality.

All services are reviewed for recipients and provider abuse. Willful abuse by the provider may result in his suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he receives.

No claim shall be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, no claims shall be paid for services that required, but did not have, prior authorization by the Kentucky Medicaid Program.

No claims shall be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting

(A) his initial or continued right to any such benefit or payment, or

(B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eleigibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully—

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Appeal Process for Refund Requests

In the event of a refund request subsequent to a postpayment review by the Surveillance and Utilization Review Branch (SURS), the provider may appeal the Medicaid agency request in writing by providing clarification and documentation that may alter the agency findings.

If there has been no written response within forty-five (45) days of the refund request, assent to the findings shall be assumed. If no arrangements for payment are made, the amount requested shall be deducted from future payments.

Written clarification shall be sent to:

Director, Division of Program Services
Department for Medicaid Services
Cabinet for Human Resources
Third Floor East
275 East Main Street
Frankfort, KY 40621

III. CONDITIONS OF PARTICIPATION

A. Definition of Agency

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, whose primary purpose is to provide nursing services on an intermittent or part-time basis and other therapeutic services such as: physical therapy, speech pathology, occupational therapy, home health aide services, medical social services, nutritional counseling services, and medical supplies. These services are provided within the scope and limitations set forth by the patient's physician within a plan of treatment.

In order to receive reimbursement from Medicaid for home health services rendered to eligible recipients, the home health agency shall be granted a Certificate of Need, be licensed as a home health agency, and be certified for participation under Title XVIII (Medicare) and Title XIX (Medicaid).

Information and forms necessary to complete an application to participate in Medicaid are:

1. Application for Participation (MAP-343); and
2. Provider Information Sheet (MAP-344)
3. Copy of Medicare certification
4. Electronic Media Billing Agreement, MAP-346 and Provider Agreement Addendum (MAP-380) for electronic billing

The yellow copy of the Application for Participation (MAP-343) shall be returned to the agency along with a cover letter indicating the provider number, and effective date of participation.

Questions regarding enrollment may be addressed to the Provider Enrollment Section, Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, telephone: 502-564-3476.

SECTION III - CONDITIONS OF PARTICIPATION

B. Out-of-State Providers

The out-of-state provider, in addition to the participation requirements listed in A., shall specify whether services will be provided inside Kentucky or in their own state. If services are provided in Kentucky, the home health agency shall have a Kentucky Certificate of Need and appropriate license. If the services are to be provided in their own state, the home health agency shall be a Medicare-certified home health agency and have a license to operate in that state.

C. Change of Ownership

The home health agency shall complete new participation agreement forms whenever the agency has had a change of ownership. The information and forms necessary to complete the application to participate in Medicaid are:

1. Application for Participation (MAP-343); and

2. Provider Information Sheet (MAP-344); and

3. Copy of Medicare certification

4. Electronic Media Billing Agreement, (MAP-346) and Provider Agreement Addendum, (MAP-380) for electronic billing.

These forms shall be submitted along with a cover letter stating that this represents a change of ownership, giving the old agency, the name of the new agency and the effective date of the change.

D. Disclosure of Information (42 CFR 405, 420, 413 and 455)

There are some requirements for disclosure of information by institutions and organizations providing services under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act.) The Federal regulations implement sections 3, 8, 9, and 15 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142). The portions applicable to Medicaid are outlined for you. The regulations are significant and we suggest your attention to them.

Of particular impact on Medicaid providers are the following:

1. The Secretary of the Department of Health and Human Services or the State agency may refuse to enter into or renew an agreement with a provider if any of its owners, officers, directors, agents, or managing employees has been convicted of criminal offenses involving any of the programs under Titles XVIII, XIX, or XX.

2. The Secretary or State agency may terminate an agreement with a provider that failed to disclose fully and accurately the identity of any of its owners, officers, directors, agents, or managing employees who have been convicted of a program-related criminal offense at the time the agreement was entered into.

3. The Secretary may have access to Medicaid provider records.

4. Providers are required to disclose certain information about owners, employees, subcontractors, and suppliers.

In addition to these new requirements, the Federal regulations detail revisions to existing sections on bankruptcy or insolvency and provider agreements, and note information which may be requested concerning business transactions.

E. Patient Consent Forms

Please be advised that neither the Office of Inspector General (Licensing and Regulation or Audits) nor Medicaid personnel are required to have completed patient consent forms prior to or upon reviewing or investigating patient records or provider records which relate to the Kentucky Medicaid Program. (See Section III. H. Medical Records of this Manual regarding inspection of records.

SECTION III - CONDITIONS OF PARTICIPATION

F. Termination of Provider Participation

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medicaid Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standard;

3. Misrepresenting factors concerning a facility's qualifications as a provider;

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medicaid Program may terminate the provider agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the provider by registered or certified mail with return receipt requested. Otherwise, the Kentucky Medicaid Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medi caid Program;

4. The earliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

The provider receiving a notice may request an evidentiary hearing. The request shall be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following.

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;

3. Counsel representing the provider;

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and

5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources.

These procedures apply to any individual provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medicaid Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medicaid Program. Adverse action taken against an individual provider under Medicare shall be appealed through Medicare procedures.

G. Withdrawal of Participation

If a provider terminates Medicaid participation, written notice shall be given to the Cabinet for Human Resources, Department for Medicaid Services at least thirty (30) days prior to the effective date of withdrawal. Payment may not be made for services or items provided to recipients on or after the effective date of withdrawal.

H. Medical Records

Medical records shall substantiate the services billed to Medicaid by the home health agency. The medical records shall be accurate and appropriate. All records shall be signed and dated.

Medical records shall be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit or other dispute. The records and any other information regarding payments claimed shall be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection and copying by Cabinet personnel.

SECTION III - CONDITIONS OF PARTICIPATION

I. Patient Rights

As required by the Medicare Program: Home Health Agencies: Conditions of Participation (42 CFR part 484) and therefore, also the Medicaid Program, there are certain rights to which home health patients are entitled and home health agencies shall promote and protect the rights of each individual under their care, including each of the following rights:

1. The right to be fully informed in advance about the care and treatment to be furnished by the home health agency, to be fully informed in advance of any changes in the care or treatment to be furnished by the agency that may affect the individual's well-being, and (except with respect to an individual determined to be incompetent) to participate in planning the care and treatment or changes in care or treatment;

2. The right to voice grievances without discrimination or reprisal for voicing grievances with respect to treatment or care that is (or fails to be) furnished;

3. The right to confidentiality of the clinical records;

4. The right to have one's property treated with respect;

5. The right to be fully informed orally and in writing (in advance of coming under the care of the agency) of;

   All items and services furnished by (or under arrangements with) the agency for which payment may be made under Medicare or Medicaid;

   The coverage available for items and services under Medicare, Medicaid, and any other Federal program of which the agency is reasonably aware;

   Any charges for items and services not covered under Medicare or Medicaid and any charges the individual may have to pay regarding items and services furnished by (or under arrangements with) the agency; and

Any changes in the charges or items and services for which the individual may be liable.

6. The right to be fully informed in writing (in advance of coming under the care of the agency) of the individual's rights and obligations under Medicaid.

7. The right to be fully informed of the availability of the State home health agency hotline.

It shall be the responsibility of the Division for Licensing and Regulations, the Kentucky state survey agency, to assure compliance with the Patients Rights requirements and standards for meeting these requirements under the Medicaid Program.

J. Advanced Directives

Section 4751 of OBRA 1990 requires that adults, eighteen (18) years of age or older, receive information concerning their right to make decisions relative to their medical care. This includes 1) the right to accept or refuse medical or surgical treatment, 2) the right to execute a living will, and 3) the right to grant a durable power of attorney for their medical care to another individual.

These requirements were effective December 1, 1991, as follows, regardless of payer source:

* A hospital shall give information at the time of the individual's admission as an inpatient.

* A nursing facility shall give information at the time of the individual's admission as a resident.

* A provider of home health care shall give information to the individual in advance of the individual's coming under the care of the provider.

* A hospice program providers shall give information at the time of initial receipt of hospice care by the individual.

Additionally, providers shall

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

(b) Provide written information to all adult individuals on the provider's policies concerning implementation of these rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

SECTION III - CONDITIONS OF PARTICIPATION

State law allows for a health care provider or agent of the provider to object to the implementation of advance directives. For additional information, refer to KRS 311.634 and KRS 311.982 or consult an attorney.

The following materials are included in the appendix of this manual.

1) Description of Kentucky laws regarding the
   a) Living Will Act
   b) Health Care Surrogate Act
   c) Durable Power of Attorney

2) Living Will Declaration

3) Designation of Health Care Surrogate

4) Advance Directive Acknowledgment

5) Protocol

The cost of reproducing these materials in Medicaid-eligible individuals shall be a Medicaid allowable cost for Medicaid-eligible individuals.

While the requirements for this process are listed above, providers may choose to advise those individuals receiving services prior to December 1, 1991, regarding advance directives.

NOTE: Advanced directives apply for all home health recipients, even those who are "supply only" recipients through the Home Health Program.

SECTION IV - SERVICES COVERED

IV. SERVICES COVERED

Home health care is the provision of medical care and supportive services to a sick or disabled person in his place of residence. The home health agency is responsible for delivering this care to an eligible Medicaid recipient. A large part of the medical care involves teaching the patient or family, whenever possible, to be able to provide the care. Recipients shall be accepted for treatment by the home health agency on the basis of a reasonable expectation that the recipient's health needs may be adequately met by the agency in the recipient's place of residence. All services shall be medically reasonable and necessary to the treatment of the recipient's illness or injury, and it shall be reasonable and necessary that the service be provided in the home setting. All recipients shall have a home health plan of care and medical records which indicate that the above requirements have been met.

A. Eligibility for Services

Home health services are available to eligible Kentucky Medicaid recipients regardless of age. Eligibility of a recipient for home health services does not depend upon his need for or discharge from institutional care. **Eligibility for home health aide services is not limited to recipients requiring nursing or therapy services.** A recipient who requires only home health aide services with the supervision, evaluation, and coordination by the registered nurse , may be considered for coverage. This would include the recipient with limitations due to senility or a psychiatric problem necessitating the provision of aide services. The supervision requirements for home health aide services shall be met, however, with the supervisory visits considered as administrative cost and not directly reimbursable. In order to be eligible to receive medical social services, the recipient must also be receiving either nursing, therapy, or home health aide services (refer to specific service covered section (IV, B) for additional information regarding medical social services.)

SECTION IV - SERVICES COVERED

1. ELIGIBILITY CONSIDERATIONS - CONDITION OF RECIPIENT, SERVICES PROVIDED, AND ABSENCES FROM THE HOME

The Medicaid Home Health Program does not require specifically that the recipient be labeled essentially homebound in order to be eligible to receive home health services. The medical condition of the recipient and the services to be provided shall be considered when determining if it is reasonable to request Medicaid reimbursement for home health services. Recipients may be eligible for home health based on the following considerations:

a. Medical condition of the recipient

The medical condition of the recipient shall be considered when determining if it is reasonable and necessary to request Medicaid reimbursement for home health services. There shall be a diagnosis of illness or injury and there shall be medical care needs related to that diagnosis. Consideration shall be given to the degree of difficulty the recipient has in getting around and making trips away from his home (e.g. degree of fatigue, shortness of breath, sensory problems, and functional limitations); consideration shall be given to the amount of assistance necessary to transport the recipient; and consideration shall be given to the mental condition of the recipient.

Examples of these considerations would be: a recipient who is paralyzed from a stroke and confined to a wheelchair could require considerable assistance on the part of another person or a special van; a recipient who is blind or senile could require the assistance of another person in leaving his place of residence; the recipient who has returned from a hospital stay involving surgery could be suffering from resultant weakness and pain, and therefore, have had his activities restricted by the physician or by his medical condition; a recipient with arteriosclerotic heart disease of such severity that he must avoid all stress and physicial activity; and a recipient with psychiatric problems whose illness is manifested in part by a refusal to leave his home environment or have his illness be of such a nature that it would not be considered safe for him to leave his place of residence unattended even if he has no physical limitations.

b. Services to be Provided

The services to be provided shall also be considered when determining if it is reasonable to request Medicaid reimbursement for home health service. There are instances when it is appropriate that the service be provided in the home setting. There are instances when neither the fact that a recipient is able to be away from his home with difficulty nor the purpose of his trips away from home would have a bearing upon the appropriateness of providing home health services under the Medicaid Program.

Examples of this consideration would be: A recipient requires only personal care service which could be provided by the home health aide; the patient needs to be taught to perform a procedure that most appropriately should be taught in the home setting where the procedure is to be performed, such as colostomy irrigation or self-catherization; prefilling insulin syringes when the recipient is unable to do this and there are no family members who can be taught; or providing medically reasonable and necessary supplies.

c. Absences from the home shall be considered:

Evaluations are to be made of the frequency and purpose of the trips, in light of the services required as a result of the medical condition. Absences from the home for the purpose of receiving medical services do not necessarily preclude the provision of in-home services. Some examples of specific considerations are: a recipient is required to go to dialysis three days a week but also needs diabetic monitoring and insulin syringes filled once a week; a recipient who is very functionally involved needs to go to the hospital outpatient department for physical therapy because of the special equipment available but also needs to continue to receive occupational therapy at home; a recipient requires personal care services which are only available in the home setting.

Absences from the home for educational purposes would not prevent the recipient from receiving home health services if other requirements have been met.

Lack of transportation is not a consideration for seeking Medicaid reimbursement for home health services.

It is not the intent of the Medicaid Program that recipients never leave their home for non-medical reasons. It is recognized that people must be able to leave their homes on occasion even though it does require a considerable and taxing effort.

It is the intent of the program, however, that reimbursement for the more expensive in-home services not be requested if the recipient is able to be away from his home and could receive these services in an outpatient setting. To achieve this objective, a considerable amount of responsibility rests with the home health agency to screen the referrals received and assure that only those recipients who qualify are accepted for services.

2. Definition of Place of Residence

The recipient's place of residence is wherever he makes his home. This may be his own dwelling, an apartment, a relative's home, or a personal care home. An institution which meets the definition of a hospital or nursing facility, shall not be considered as the recipient's home for the purpose of determining coverage for home health services. Additionally, services rendered in a school, day care center, or Head Start center shall not be considered valid places of service. Place of service shall not be a nursing facility for Medicare coinsurance and deductible claims.

3. Plan of Care

Recipients are accepted for treatment on the basis of a reasonable expectation that the recipient's medical, nursing, and social needs can be met adequately by the agency in the recipient's place of residence. Services shall follow a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

The plan of care is developed by the physician in consultation with appropriate professional agency staff. The plan of care shall contain all pertinent diagnoses including the recipient's mental status; services needed, including supplies and equipment required; frequency of visits to be made; prognosis; rehabilitation potential; functional limitations; activities permitted; nutritional requirements; medications and treatments; any safety measures to protect against injury; instructions for timely discharge or referral; and any other appropriate items.

Services provided before the physician signs the plan of care are considered to be provided under a plan established and approved by the physician if there is a verbal order for the care received prior to providing the services and the verbal order is documented in the medical record. The services shall be included in a signed plan of care. If the physician refers a recipient under a verbal plan of care, the agency shall forward its written record to the physician who shall sign and return it to the agency. If the physician refers a recipient under a plan of care that cannot be completed until after an evaluation visit, the physician shall be consulted to approve additions or modifications to the original plan. Any additions or modifications to the original plan of care are to be indicated on a change of order form, signed by the physician and included in the recertification. Orders for therapy services are to include the specific procedures and modalities to be used and the amount, frequency, and duration of the therapy service.

Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff shall check all medicines a recipient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies and contraindicated medication, and promptly report any problem to the physician.

The orders on the plan of care shall indicate the type of services to be provided, nature of service, frequency of the service and expected duration. Orders for care can indicate a specific range in the frequency of visits to ensure that the most appropriate level of service is provided. When a range of visits is ordered, the upper limit of the range is to be considered the specific frequency. It is not acceptable for the orders to state 3x per week and PRN. This is not a specific order because the number of weeks is not specified; PRN is open ended; and the nature of the service is not specified. An example of an acceptable order would be 3x per week x4 weeks and PRN x2 to perform a specific service. Orders for therapy services are to include the specific procedures and modalities to be used and the amount, frequency and duration. The therapist and other agency personnel shall participate in developing the plan of care.

It is acceptable to utilize the same plan of care forms required by Medicare or another form which meets all licensure and certification requirements for a plan of care. The status of each recipient and the plan of care shall be reviewed at such intervals as the severity of the recipient's illness requires but no less frequently than every two months, with a maximum of sixty-two (62) days, by home health agency staff and the physician. The physician shall sign and recertify the plan of care no less frequently than every two months, with a maximum of sixty-two (62) days.

B. SPECIFIC SERVICES COVERED

The following services are included as covered services through the home health services element of Medicaid when provided to an eligible recipient in his place of residence and ordered by a physician in a plan of care:

1. Nursing Services

Part-time or intermittent nursing services, as defined in the Kentucky Nursing Practice Act, are covered when provided by a registered nurse or a licensed practical nurse who is under the supervision of a registered nurse, according to the direction of the recipient's physician. The services shall require the skills of a registered nurse or a licensed practical nurse, and shall be reasonable and necessary to the treatment of the patient's illness or injury. Most recipients accepted for home health care will require more than one visit; however, there may be some instances where a single visit is all that is needed. A ONE TIME VISIT FOR GENERAL LABORATORY SCREENING SERVICES, HOWEVER, IS NOT A COVERED SERVICE (FOR EXAMPLE, SERVICES WHICH MIGHT BE PERFORMED ANNUALLY, SEMI-ANNUALLY, OR QUARTERLY FOR PATIENTS IN PERSONAL CARE FACILITIES).

Coverage shall not be available for full-time nursing care under the Kentucky Medicaid Home Health Program. Additionally, coverage for daily nursing visits (except for unusual and complicated situations) is limited to short periods of time. Short periods of time may be defined as up to thirty (30) days. Examples of daily nursing visits would be as follows: daily visits to change a dressing following a surgical procedure or to teach the patient or family; daily visits to give insulin injections during the period of time when the agency is training the recipient or a family member how to administer the injections or when the agency is trying to make arrangements with another person who is able and willing to administer the injections; and administration of IV antibiotic therapy.

a. Standard: Duties of the Registered Nurse.

The registered nurse makes the initial evaluation visit, regularly re-evaluates the recipient's nursing needs, initiates the plan of care and necessary revisions, furnishes those services requiring substantial and specialized nursing skill, initiates appropriate preventive and rehabilitative nursing procedures, prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the recipient's condition and needs, counsels the recipient and family in meeting nursing and related needs, participates in inservice programs, supervises and teaches other nursing personnel and supervises the home health aide.

b. Standard: Duties of the Licensed Practical Nurse.

The licensed practical nurse provides services in accordance with agency policies and the Kentucky Nursing Practice Act, prepares clinical and progress notes, assists the physician and registered nurse in performing specialized procedures, prepares equipment and materials for treatments observing aseptic technique as required, and assists the recipient in learning appropriate self-care techniques.

c. Specific Guidelines for Nursing Service.

Nursing services shall be medically reasonable and necessary for the treatment of an illness or injury, and shall require that they be performed by or under the direct supervision of a licensed nurse. In determining whether a service requires that it be performed by a nurse, consideration shall be given to the inherent complexity of the services and the medical condition of the recipient. In many instances, the service may be classified as a nursing service on the basis of its complexity alone (i.e. intravenous or intramuscular injections, insertion of a catheter). There are other instances where the nature of the service AND the condition of a recipient would affect whether the service may only be performed safely and effectively by the nurse or is able to be performed by the home health aide or a non-medical person. For example, the giving of a bath does not generally require that it be performed by the licensed nurse. Consequently, it would usually not constitute a covered nursing service even though it may have been performed by a nurse, unless the recipient's condition was of such severity that it would not be safe for the service to be performed by anyone but a nurse.

d. Observation and Evaluation

Nursing visits ordered by the physician for observation and evaluation of the recipient's condition may be covered provided: a reasonable probability exists that significant changes may occur which would require the physician or nurse's service to evaluate the need to change the plan of care; or the recipient's illness has become relatively stabilized but the physician determines a risk of future complications from the illness or injury exists which could require the skilled observation techniques of the nurse. Visits falling into this category would be infrequent; for example, monthly for a limited period of time. Frequent visits when no changes could be anticipated shall not be considered medically reasonable or necessary. Recipients or family members should be taught to observe for signs and symptoms of possible complications which should be reported to the physician or the nurse. If a recipient's condition has not changed for several months, very careful consideration should be given as to the necessity or reasonableness of continuing service.

e. Psychiatric Service

The following guidelines relate to the provision of psychiatric service through the Home Health Program.

It has been determined that supporting services including drawing blood for serum lithium levels, administering Prolixin injections, and monitoring medications for side effects may be covered through the Home Health Program provided that:

(1) Recipient is not an active case of the community mental health center and does not receive chemotherapy from a community mental health center;

(2) Recipient meets the eligibility criteria for home health services;

(3) The service has been ordered by a physician;

(4) The service shall be medically reasonable and necessary.

It is the responsibility of the staff of the home health agency to verify that the recipient is not being followed by the community mental health center, but rather by the referring physician.

Psychiatric services including counseling, psychotherapy or other mental health related services will not be reimbursed under the Home Health Program of the Department for Medicaid Services. Community mental health centers are reimbursed to provide these services either directly or through contractual arrangements with the necessary follow-up required preventing possible fragmentation of services. Home visits are a covered service under the community mental health center program.

To avoid possible duplication of service, the home health agency and the community mental health center would need to enter into contractual arrangements to serve identified psychiatric needs of the area. The community mental health center would continue to be the primary responsible agency and any reimbursement would be through the community mental health center element of the Department for Medicaid Services to the community mental health center.

f. Examples of Some Specific Covered Nursing Services

1. The pre-filling of insulin syringes with monitoring of the recipient's diabetic condition may be a covered service provided there is no one who can be taught to perform this service.

2. Prefilling medication dispensing system when there is no one who can be taught to perform the service.

g. Examples of Non-Covered Nursing Service

1. Nursing visits to perform glucometer testing are not covered as it generally does not require the skills of a nurse to perform these tests.

2. Therapy Services

As appropriate, physical, occupational, or speech therapy may be provided by the home health agency directly or under contractual arrangement by a qualified therapist or a qualified therapist assistant under the supervision of a qualified therapist in accordance with the plan of treatment. (Refer to Medicare Conditions of Participation for Home Health Agencies 42 CFR Part 484.4 for qualifications of therapist and therapist assistant.) The qualified therapist assists the physician in evaluating the level of function, helps develop the plan of treatment (revising as necessary), prepares clinical and progress notes, advises and consults with other agency personnel and participates in inservice programs.

SECTION IV - SERVICES COVERED

A recipient may qualify under Medicaid requirements if any one of the therapy services is needed, provided that the eligibility requirements for Home Health Service are met. Refer to Eligibility Services Section IV, A., pages 4.1-4.4.

a. Physical therapy shall include:

(1) Assisting the physician to evaluate the recipient for physical therapy through the application of muscle, nerve, joint and functional ability tests;

(2) Therapeutic exercise program by therapist including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, and increased range of motion;

(3) Gait evaluation and training;

(4) Transfer training and instructions in care and use of wheelchairs, braces, prosthesis, etc;

(5) Instruction in breathing exercises, percussion, postural drainage, vibration for pulmonary functioning;

(6) Teaching compensatory technique to improve the level of independence in activities of daily living; and

(7) Training and instructions for patient or family in setting up and following a physical therapy program.

The services shall be reasonable and necessary for the recipient's condition and of such complexity that they must be performed by the qualified therapist. A maintenance program shall be developed for the performance of simple procedures which could be safely and effectively provided by the recipient, family or home health aide.

b. Occupational therapy shall include:

(1) Assisting the physician to evaluate the recipient for occupational therapy services through the appropriate testing technique;

(2) Therapeutic exercise program provided by the therapist including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, and increased range of motion;

(3) Assisting recipients to obtain better coordination, use of senses and perception

(4) Instructing the recipient or family in setting up and following an occupational therapy program;

(5) Teaching compensatory technique to improve the level of independence in activities of daily living; and

(6) Designing and fitting orthotic and self-help devices (i.e., hand splints for the recipient with rheumatoid arthritis).

The services shall be reasonable and necessary for the recipient's condition and shall be of such complexity that they must be performed by the qualified therapist.

c. Speech pathology shall include:

(1) Assisting the physician to evaluate the recipient for speech pathology service through the appropriate testing techniques;

(2) Determining and recommending appropriate speech, language, hearing, dysphagia and oral feeding services;

(3) Providing necessary rehabilitative services for recipients with speech, hearing, language, dysphagia and oral feeding disabilities.

(4) Instructing the recipients and family in setting up and following a speech pathology program.

The services shall be reasonable and necessary for the recipient's condition and of such complexity that they must be performed by the qualified therapist.

3. Home Health Aide Services

The home health aide provides services in accordance with the care plan and under the written instructions for recipient care and supervision provided by the registered nurse or therapist, as appropriate. Home health aide service may be provided directly by the home health agency and by contractual arrangements. The duties of the aide include: the performance of simple procedures as an extension of therapy services; personal care (i.e. bathing, shampoo, special foot care); range of motion exercises and ambulation; assistance with medications that are ordinarily self-administered and which have been specifically ordered by the physician; reporting changes in the recipient's condition and needs; and completing appropriate records. The home health aide may also perform incidental household services which are essential to the recipient's health care at home WHEN PROVIDED IN THE COURSE OF A REGULAR VISIT (i.e., straightening room, or changing linens). Domestic or housekeeping services which are unrelated to the recipient's care are not covered under the Medicaid Home Health Program.

SECTION IV - SERVICES COVERED

In order for the services of the home health aide to be considered reasonable and necessary, they must be services that the recipient is either physically or mentally unable to do for himself. It shall not be considered reasonable and necessary for Medicaid to pay for services which the recipient can perform for himself but chooses not to perform.

Medicaid home health services are designed to address the needs of the long-term, chronically ill recipient as well as the needs of the short-term, acutely ill recipient. For example, the recipient who mainly needs services of the home health aide, with the supervision, evaluation and coordination by the registered nurse, may be considered for coverage under the home health program.

SUPERVISION: The registered nurse or Licensed Physical Therapist if physical therapy services are provided, shall make a supervisory visit to the recipient's residence at least every two weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met.

Visits made to evaluate the aide services or to supervise or instruct the home health aide are considered (as) administrative costs and are not directly reimbursable.

TRAINING OF HOME HEALTH AIDES: The home health agency shall be responsible for assuring that the home health aide meets the training and competency evaluation or a competency evaluation requirements as outlined in Conditions of Participation for Home Health Agencies in 42 CFR Part 484.

4. Medical Social Services

Medical social services are a covered service when provided under the direction of the physician's plan of care by a qualified medical social worker or a qualified social work assistant under the direction of a qualified social worker, as defined by the Medicare Program: Home Health Agencies: Conditions of Participation.

Responsibilities of the social worker are to:

a. assist the physician and other team members in understanding the significant social and emotional factors related to the health problems;

b. participate in the development of the plan of care;

c. prepare clinical and progress notes;

d. assist the recipient and family to understand, accept, and follow medical recommendations;

e. assist recipient and family to recognize and change personal and environmental difficulties which predispose toward illness or interfere with obtaining maximum benefit from medical care;

f. evaluate the need for and utilize other support resources available within the community to enable the recipient to remain at home;

g. participate in discharge planning and inservice programs;

h. act as a consultant to other agency personnel.

A recipient requiring **ONLY** medical social services shall not meet Medicaid home health guidelines for coverage. If a recipient has been accepted for home health care under a plan of care for medical social services in addition to other services (nursing, therapy or home health aide), coverage may continue for completing the social work plan after the recipient's care plan has been closed to other services, provided a recertification is not due. A recipient shall not be recertified for medical social services only.

5. Disposable Medical Supplies

Disposable medical supplies are a covered home health service. Payment may be made for those medical supplies which are essential in providing the treatment which the physician has ordered for the recipient and which are in keeping with accepted medical practice. The plan of care or recertification shall support the need for the supplies. When appropriate, the specific items and directions for use must be included as part of the physician's plan of care and recertification.

Supplies, such as syringes, which are relatively inexpensive and are needed frequently in the treatment of a recipient, are billed collectively by the type of supply used. If the supplies are rarely used, they should be considered part of the routine or "bag supplies" and are to be included as administrative cost. The necessity for one swab, one band-aid or one 4 x 4 bandage should not initiate a request for payment.

Program funds have prohibited the indiscriminate reimbursement for supplies from which the recipient might benefit. Reimbursement shall be limited to the supplies actually used on the recipient and considered within the norm of accepted practice. For example, an apron used by the nurse, for protection of both the nurse and recipient, is not used on the recipient as a part of the treatment, therefore, it shall not be considered as a covered medical supply. Gloves that are used in treatment of an open wound requiring extensive handling of dressings, which would be impractical to do with sterile forceps to prevent contamination, are considered reimbursable; however, gloves used for protection of the nurse or aide shall not be billable as a covered medical supply, but are an allowable administrative cost.

The cost of supplies for personal hygiene is considered outside the services covered under the home health program. Examples of items considered as used for personal hygiene would be; soap, shampoo, toothpaste, toothbrush, wash cloths, towels, deodorant, and shaving lotion. Therapeutic supplies including lotions or powders used in rendering nursing care to a bedfast recipient are considered as reimbursable items, if deemed essential in providing the degree of care which the physician has ordered for the bedfast recipient.

In the event a recipient is not in need of home health visits but has a condition that requires disposable medical supplies to maintain him in the home, vendor payment may be made under the home health program. The procedures required for coverage of these supplies through the home health agency will be as follows:

The physician shall certify that the disposable medical supplies are medically required. The physician is to sign and date a completed Certification for Medical Supply Form (MAP-248). There may be instances where the physician orders supplies on another type of form such as a prescription form. It shall still be necessary for the agency to have the physician sign and date the completed Certification for Medical Supply Form. A new physician's certification is to be completed and signed every 6 months or earlier if a change occurs in supplies requested.

When the services provided are limited to disposable medical supplies, it is not required that the agency open a complete recipient record. However, records shall be maintained which include the physician's certification and orders, and any other pertinent information.

The UB-82 (HCFA-1450) is to be completed in the usual manner.

Examples of Covered Supplies Include But are Not Limited To:

-Adapters;
-Applicators;
-Drainage supplies;
-Dressing supplies;
-Catheter, ileostomy and ureostomy supplies;
-Colostomy supplies;
-Detection reagents for other than sugar or ketone;
-Diapers, underpads and incontinent pants (not covered before age 3);
-Egg crate mattress;
-Enema and elimination supplies including fleets enema or dulcolax suppos tory;
-Gastrostomy supplies;
-Gloves (clean or sterile);
-Inhalation therapy supplies;
-Irrigation solutions;
-IV therapy supplies including solutions unless a drug has been added to the solution by the pharmacy in which case it should be billed by the pharmacy;

-Lambs wool pads or synthetic pads;
-Lotions - powders - cream (invalid or bedfast patient);
-Nipples (specially designed for cleft palate only);
-Inexpensive occupational therapy supplies including plastic utensil holder and long arm reacher;
-Suction supplies;
-Support supplies including antiembolism stockings, support vest, support gauntlet, or support glove;
-Syringes and needles (excluding insulin syringes for diabetic);
-Tracheostomy supplies;
-Tubing.

*DRUGS - NOTE: Drugs are not included as disposable medical supplies.

Payment is made by Medicaid for covered drugs through the pharmacy program. The drugs are included on the Medicaid Drug List or approved by the special Drug Pre-authorization Project. Please refer to Appendix XII for a copy of "Drug Preauthorization Policies and Procedures" from Pharmacy Services Manual. The telephone number for Drug Preauthorization is (800) 756-7558 (in-state) and (502) 227-9073 (out of state).

6. Enteral Nutritional Products

Coverage shall be available through the Home Health Program for enteral nutritional products. Enteral nutritional products may be either ingested orally or delivered by tube into the gastrointestinal track. Coverage shall be available for enteral nutritional products which provide for the total nutrition of the recipient or for supplemental nutrition. However, these products shall be covered when provided as an integral part of a treatment plan which the physician has ordered for the recipient. The recipient shall also be receiving covered home health visits by at least one of the following disciplines; nursing, home health aide, physical therapy, speech therapy, or occupational therapy. These visits may be covered by Medicare, Medicaid, or an insurance policy. Coverage for enteral nutritional products shall not be available as a "stand alone" service as is possible for disposable medical supplies.

The revenue code for enteral nutritional products is 279. For reporting purposes, these items shall report in the general disposable medical supply category and be subject to the same reimbursement principles and interim reimbursement rate established for disposable medical supplies.

C. Exclusions from Coverage (Services and Supplies)

The following services and supplies are excluded from coverage under the Department for Medicaid Services home health program:

1. Domestic or housekeeping services which are unrelated to recipient care;

2. Transportation services, i.e. from place of residence to a facility to receive services;

3. Drugs;

4. Newborn or post-partum service without the presence of medical complications except for the first week following a home delivery;

5. Disposable diapers shall not be covered before the recipient is 3 years of age regardless of medical condition. Age 3 and over disposable diapers are covered if medical condition and diagnosis indicate the need;

6. Services for which the recipient has no obligation to pay and for which no other person has a legal obligation to pay.

D. Hospice Service Relation To Home Health

Home health services are not covered for recipients who have elected to receive Medicare or Medicaid Hospice care when the service provided IS related to the terminal condition;

When the service to be provided by the home health agency is NOT related to the terminal illness an arrangement shall be made between the hospice provider and the home health agency. In that case, the hospice provider would notify Medicaid and request approval for the home health service. A MAP-397 shall be sent to the home health agency by the hospice provider and the home health agency shall attach the MAP-397 to the home health bill for that particular approved service.)

E. End Stage Renal Disease (ESRD) Services Relation to Home Health

Payments shall not be made through the Home Health Program for services provided in the home to end stage renal disease recipients (ESRD) receiving dialysis either at the dialysis clinic or at home. If the care provided to the recipient is dialysis related, that care is the responsibility of the ESRD facility. An example would be treating an infected shunt site or epogen injection. Home health services which are not ESRD-related may be considered for the home health recipient who is also receiving dialysis. Examples would be treating an abandoned shunt site or decubitus wound care.

SECTION V - REIMBURSEMENT

V. REIMBURSEMENT

A. REIMBURSEMENT POLICY

1. Services Provided In-State

Home health agencies shall be reimbursed on the basis of a retrospective cost reimbursement system subject to upper limits established by Medicaid. Each agency shall complete an annual cost report. This report is used to establish the Medicaid reimbursable cost and the interim rates and shall be requested by the Medicaid Program on an annual basis.

When a home health agency undergoes a change of ownership, the new owner shall be recertified by the Medicaid Program and issued a new vendor number; however, the new owner shall continue to be reimbursed at the rates in effect.

Home health agencies new in the program shall be paid seventy percent (70%) of the Medicaid maximum rate, until a fiscal year end cost report is available, not to exceed the Medicare upper limits for home health visits. During this initial period, the rate can be adjusted if the provider documents the justification for a rate change by the submittal of a projected cost report.

Payments for covered home health services provided to eligible recipients shall be made on the basis of an interim rate established by Title XIX (Medicaid), subject to Program maximums. The Medicaid interim rate shall be determined by utilizing Medicaid costs and visits, and therefore may vary from the Medicare interim rate. A cost settlement shall be completed at the end of the Agency's fiscal year. It shall be noted that the Title XVIII Principles of Reimbursement shall be utilized as a basis for cost settlement for areas not covered in the Title XIX Reimbursement Manual. The agency shall bill their usual and customary reasonable charge for all services, including disposable medical supplies and enteral nutritional products. This is the agency's charge to all recipients for the same or similar service.

2. Services Provided Out-of-State

Home health agencies that provide services outside the Commonwealth of Kentucky shall be reimbursed the lower of their usual and customary actual billed charge, Medicare upper limit or Kentucky Medicaid upper limit. In addition, supplies and enteral nutritional products shall be paid at 80% of the usual and customary actual billed charge.

B. Reimbursable Home Visits

The following explanations are included to clarify the counting and reimbursement of home health agency visits. A visit is a personal contact by a covered staff member of the home health agency or by others under contract or arrangement with the home health agency in the recipient's place of residence, made for the purpose of providing a home health service. Covered services are defined in Section IV, Services Covered.

1. Evaluation Visit

An initial evaluation visit shall be made by the registered nurse or therapist if therapy is the only service ordered. The evaluation visit shall include any nursing procedures ordered by the physician as well as (but not be limited to) the following: an evaluation of the home situation; obtaining health information; performing a health assessment; a determination of the ability of the recipient to manage in meeting his needs in the absence of the home health agency staff; a determination of the availability of family members or other appropriate people to assist in the care of the recipient as indicated; a determination that appropriate physical facilities are available; and a determination that the home health care which could be provided by the home health agency would be an appropriate level of care for the recipient. The evaluation visit is a directly reimbursable visit unless it is determined that the recipient does not qualify for home health services. Also, the evaluation visit shall not be billed to Medicaid when the home health services are to be billed to Medicare.

Most recipients accepted for home health care will require more than one visit; however, there may be some instances where a single visit to perform a service is all that is needed.

A one-time visit for general laboratory screening services, however, is not a covered service (for example, services which might be performed annually, semi-annually, or quarterly for patients in personal care facilities).

2. Counting of Visits

If one person or discipline visits the recipient's home more than once during the day because the recipient's medical condition required a second visit, it is counted as two visits. The only discipline which shall bill for more than one visit per day is nursing. Visits by nursing in excess of two per day are not covered.

If a visit is made by two or more disciplines from the Home Health Agency for the purpose of providing separate and distinct types of services, each is counted. Multiple visits to the recipient's home on the same day should be closely evaluated by the home health agency, and, whenever possible, coordination should be worked out between agency staff so staff members will not be visiting on the same day. This would provide the recipient with more days of contact with someone from the agency.

If a visit is made simultaneously by two or more persons from the home health agency to provide a single service, for example where one person supervises or instructs the other, it is counted as one visit. If a visit is made to a residence containing two recipients this would be counted as two visits only if separate and distinct services were provided to both recipients (i.e., a medical social worker visits the home to assess the home situation and the need for support services from the community, this would be considered as a single service and should be counted as a visit for only one of the recipients).

C. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by Medicaid, whether due to erroneous billing or payment system faults, shall be refunded to Medicaid. Sufficient documentation and explanation of refund shall be attached to the refund check in order to process the refund correctly. Refund checks should be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS
P.O. Box 2009
Frankfort, KY 40602

ATTN: Cash/Finance Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse, and prosecuted as such. Please refer to Section X, General Information-EDS, for further information.

D. ADJUSTMENT

An incorrect payment of an entire claim or line item would need to be corrected through the adjustment process, and would not be refunded unless the entire amount was billed in error. Please refer to Section X, General Information-EDS, for further information.

E. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which, as an adjunct to the Kentucky Medicaid Program, provides certain categories of medical recipients with a primary physician or family doctor. Only those recipients who receive Medicaid under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories are covered by KenPAC. Specifically excluded are: the aged, blind, and disabled categories of recipients; nursing facility (NF) and personal care (PC) residents; mental hospital patients; foster care cases; refugee cases; all spend-down cases; and all Lock-In cases. To aid in distinguishing from regular Medicaid recipients, the KenPAC recipients will have a color-coded Medicaid card with the name, address, and telephone number of their primary care provider.

Primary physician specialists or groups who may participate as primary physicians are:

General Practitioners	Obstetricians	Primary Physician Clinics
Family Practitioners	Gynecologists	Primary Care Centers
Pediatricians	Internists	Rural Health Clinics

Recipients may select a primary physician or clinic who agrees to participate in Medicaid and KenPAC. Recipients not selecting a primary physician will be assigned one within their home county. A primary physician may serve up to 1,500 KenPAC recipients. Provider clinics may serve up to 1,500 recipients for each full-time equivalent physician. Primary Care Centers and Rural Health Clinics may also be assigned recipients based on the number of Registered Nurse Practitioners they have on staff.

SECTION V - REIMBURSEMENT

KenPAC primary physicians and clinics must arrange for physician coverage 24 hours per day, seven days per week. A single 24 hour access telephone number must be provided by the primary physician or clinic. This number will be printed on the recipient's KenPAC Medical Assistance Identification Card.

The following service categories shall be either provided by the primary physician or clinic or referred by the primary physician or clinic in order to be reimbursed by Medicaid.

Physician (excludes ophthalmologists and psychiatrists)
Hospital (Inpatient) (excludes psychiatric and obstetrical admissions)
Hospital (Outpatient)
Laboratory Services
Nurse Anesthetists
Rural Health Clinic Services
Home Health
Primary Care Centers
Ambulatory Surgical Centers
Durable Medical Equipment

Obstetrical care, routine newborn care, and other Medicaid covered services not included in the above list may be provided for the KenPAC recipients without prior authorization. The recipient's MAID card lists programs which are not regulated by the KenPAC system.

Services not included in the above list may be obtained by the KenPAC recipient in the usual manner.

SECTION V - REIMBURSEMENT

Referrals may be made by the primary physician to another provider for specialty care or for primary care during his absence. Home health agencies will provide services on a referral basis. The home health agency may receive the home health referral directly from the primary physician or indirectly from the specialist to whom the primary physician has referred the recipient. No special authorization or referral form is required other than the usual referral and plan of treatment form utilized by the home health agency. However, to assure that payment will be made for the home health services, the primary physician shall provide the home health agency with his Medicaid provider number, which must be entered in Block #45 of the UB-82 (HCFA-1480) billing form to signify that the service has been authorized.

After the primary physician's initial referral of a KenPAC recipient to a specialist for ongoing treatment, the specialist shall not be required to receive further specific authorizations for the duration of the illness, or at the primary physician's discretion for a period of time specified by the primary physician. The referral will include necessary service provided by the specialist AND referrals made by the specialist for related services for example home health services.

It is very important that the home health agency maintain ongoing contact with the primary physician and in those situations where a specialist has made the referral, to assure that the recipient has not changed primary care physicians and that home health services are still indicated. The recipient's card should be examined at least MONTHLY to assure that the name of the primary care physician continues to be the same as with the initial referral.

Should problems arise where the recipient changes physicians in the middle of a home health recertification period and the home health agency is continuing to provide services under the first physician's two (2) months, maximum of sixty-two (62) days certification (recertification), the KenPAC Branch of Medicaid may be contacted for assistance if the new physician will not honor the current certification of the earlier primary physician or specialist to whom the primary physician referred.

KenPAC does not alter the manner in which claims are submitted to EDS. There are no new or additional forms associated with KenPAC; however, we stress the importance of obtaining the primary care physician's provider number. IT IS MANDATORY THAT THIS NUMBER BE ENTERED IN BLOCK #45 OF THE UB-82 FORM. OMISSION OF THIS NUMBER SHALL RESULT IN A REJECTED CLAIM.

If you have further questions about the KenPAC Program you may write:

Manager, KenPAC Branch
Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621

Information and special authorization numbers may be obtained by calling toll free 1-800-635-2570 (In-State) or 1-502-564-5198 (In-and Out-of-State).

SECTION VI - REIMBURSEMENT IN RELATION TO MEDICARE

VI. REIMBURSEMENT IN RELATION TO MEDICARE

A. General Information

The Medicare Program shall be billed for services which would be covered by the Medicare Program. The Medicaid program shall not be billed for services which could have been covered by the Medicare Program. It is the responsibility of the home health agency to keep abreast of current Medicare coverage guidelines and bill according to the guidelines.

1. Deductible and Coinsurance

a. The Medicaid Program will make payment to the home health agency for the Medicare deductible and coinsurance due for services provided by the home health agency.

Services, including therapies, provided in a nursing facility are excluded from coverage. This will be edited through post-payment review.

2. Billing Instructions

a. All necessary billing should be completed with the Medicare Intermediary before any billing is submitted to EDS.

b. Upon receipt of Medicare's Remittance Advice, the home health agency may bill EDS for the deductible and coinsurance amount due for a Medicaid eligible recipient.

All Medicare deductible and coinsurance claims must be billed on a UB-82 claim form with a copy of the Medicare Remittance Advice attached.

c. There may be several recipients listed on the Medicare Remittance Advice. It is necessary to make a copy of the Medicare Remittance Advice to attach to the completed UB-82 claim form submitted to EDS. The recipient information on the Medicare Remittance Advice for which the Medicare billing statement is applicable MUST be underlined in RED.

B. Recipients who are eligible for Medicare but the services have been rejected by the Medicare Intermediary

A MAP-34 shall be completed and kept as a part of the recipient's record whenever a recipient has been rejected by Medicare and the agency will be billing the Medicaid Program for services provided. The MAP-34 block which is Block 87 on the UB-82 shall be marked with a Y to indicate that the MAP-34 is available in the recipient's record. A new MAP-34 shall be completed whenever the reason changes or at least every 12 months.

C. Reimbursement for a recipient who is eligible for Medicare when it has been determined by Utilization Review that the services would not be covered under the Medicare Program.

A MAP-34 shall be completed and kept as a part of the recipient's record whenever a recipient has been rejected by Utilization Review and the agency will be billing the Medicaid Program for services provided. The MAP-34 block which is Block 87 on the UB-82 must be marked with a Y to indicate that the MAP-34 is available in the recipient's record. A new MAP-34 shall be completed whenever the reason changes or at least every 12 months.

It is emphasized again that the Medicare Program has the primary liability to cover those services which meet the Medicare Program guidelines. The Medicaid Program has the secondary liability in relation to Medicare.

SECTION VII - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

VII. REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

A. General Information

1. General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services shall actively participate in the identification of third party resources for payment on behalf of the recipient. At the time the provider obtains Medicaid billing information from the recipient, it shall be determined if additional resources exist. Providers have an obligation to investigate and to report the existence of other insurance or liability. The provider's cooperation will enable the Kentucky Medicaid program to function efficiently.

2. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid Program, all participating providers shall submit billings for medical services to a third party when the provider has prior knowledge that a third party may be liable for payment of the services.

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions:

- -If the recipient is married or working, inquire about possible health insurance through the recipient's or spouse's employer;
- -If the recipient is a minor, ask about insurance the MOTHER, FATHER, OR GUARDIAN may carry on the recipient;
- -In cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder;
- -For people over 65 or disabled, seek a MEDICARE HIC number;
- -Ask if the recipient has health insurance such as a MEDI CARE SUPPLEMENT policy, CANCER, ACCIDENT, or INDEMNITY policy, GROUP health or INDIVIDUAL insurance, etc.

SECTION VII - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

Examine the recipient's MAID card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding the insurance.

Following is a list of the insurance codes on the MAID card:

A - Part A, Medicare only
R - Part A, Medicare Premium Paid
B - Part B, Medicare only
C - Both Parts A and B Medicare
S - Both Parts A and B Medicare Premium Paid
D - Blue Cross/Blue Shield
E - Blue Cross/Blue Shield/Major Medical
F - Private medical insurance
G - Champus
H - Health Maintenance Organization
J - Unknown
K - Other
L - Absent Parent's insurance
M - None
N - United Mine Workers
P - Black Lung

B. Billing Instructions for Claims Involving Third Party Resources

The home health agency shall complete all billing with the third party payer prior to billing EDS. After payment has been received from the third party payer, the home health agency should complete a UB-82 claim as if they were preparing a regular home health claim. They shall enter all of the services billed to the third party payer using applicable revenue codes. Separate services shall be entered on separate lines of the billing form as they would be entered on the regular home health claim. The agency shall enter the total charges on the claim in Block #53.

SECTION VII - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

(Total Claim Charge); enter the amount received from the third party payer in Block #63 (Prior Payment).

NOTE: Effective with service dates of July 1, 1989, and after, no payment shall be made for any deductible or coinsurance amounts due for durable medical equipment, braces, or prosthetics incurred as the result of billing an insurance company.

C. Forms of Documentation That Will Prevent a Claim From Denying For Other Insurance:

The following forms of documentation when attached to the claim will prevent your claim from denying because of other health insurance:

1. Remittance statement from the insurance carrier that includes:

   a. Recipient Name

   b. Date(s) of service

   c. Billed information that matches the billed information on the claim submitted to Medicaid.

   d. An indication of denial or that the billed amount was applied to the deductible.

   NOTE: Denials from insurance carriers stating additional information necessary to process claim are not acceptable.

2. Letter from the insurance carrier that includes:

   a. Recipient Name

   b. Date(s) of services

   c. Termination or effective date of coverage

   d. Statement of benefits available (if applicable)

   e. Signature of insurance representative or the letter must be on the insurance company's letterhead.

3. Letter from a provider that states their office contacted the insurance company by phone and provides the following information:

   a. Recipient Name

   b. Date(s) of service

   c. Name of Insurance Carrier

   d. Name of Insurance Representative spoken to and their phone number (or notation indicating a voice automated response system was reached)

   e. Termination or effective date of coverage

   f. Statement of benefits available (if applicable)

4. A copy of a prior remittance advice from an insurance company, can be considered an acceptable form of documentation if it is:

   a. for the same recipient

b. for the same or related service being billed on the claim

c. the date of service specified on the remittance advice is no more than six (6) months prior to the claim's date of service

If the remittance advice does not provide a date of service then the denial can only be acceptable by EDS if the date of the remittance advice is no more than six (6) months from the claim's date of service.

D. How Other Health Insurance Information Documentation Sent With Claims Is Used To Update Medicaid's Recipient Eligibility Files

When a claim is received for a recipient whose eligibility file indicates other health insurance that is active and applicable for the dates of services, types of service being billed and no payment from other sources is entered on the Medicaid claim form, the claim is automatically denied; unless documentation is attached.

EDS will review any documentation attached to a claim to determine whether it meets the above described criteria so that they can avoid denying a claim because of the recipient's other health insurance.

If the documentation is acceptable, copies of the documentation are made and forwarded to the third party unit at EDS.

If the documentation is from the insurance company, EDS will update the recipient's eligibility file to reflect the correct dates of coverage, type of coverage, etc.

When EDS receives documentation that is sufficient to process your claim, but is missing information needed to update the recipient file such as the specific date of termination, a questionnaire is sent to the insurance carrier asking them to supply the missing information. The recipient's file cannot be updated until a response is received from the insurance carrier, so all claims for the recipient will continue to require that documentation be attached.

When EDS receives copies of any documentation that does not include written verification from the insurance carrier of the change, a questionnaire is sent to the insurance carrier asking them to verify the change requested in the provider's letter. The recipient's file cannot be updated until a response is received from the insurance carrier, so all claims for the recipient will continue to require that documentation be attached. This is why it is best to submit written verification from the insurance carrier so that not only can the claim be processed, but the recipient's file can be updated promptly.

E. When You Bill the Insurance Carrier and Cannot Receive a Response Within 120 Days.

Another situation that may occur is when the other health insurance has not responded to a provider's billing within 120 days from the date of filing a claim. This process can only be used if a provider has "no response" and should not be used if a response has been received, but no payment has been.

Complete a TPL Lead Form and write "No Response in 120 Days" on either the TPL Lead Form or the claim form, attach it to the claim and submit it to EDS. EDS will override the other health insurance edits and forward a copy of the TPL Lead Form to their Third Party Unit who will contact the insurance carrier to see why they have not paid their portion of liability.

SECTION VII - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

F. Accident and Work Related Claims

For claims billed to Medicaid that are related to an accident or work related incident, the provider shall pursue information relating to the accident. If an employer, individual or an insurance carrier is a liable party, but the liability has not been determined, you may proceed with submitting your claim to EDS if you provide any information obtained; the names of attorneys, other involved parties and the recipient's employer to:

EDS
P.O. Box 2009
Frankfort, KY 40602
ATTN: TPL Unit

If you have any questions concerning how to submit your claims when other insurance is involved you may contact the EDS Provider Relations Unit at 1-800-756-7557 for assistance.

G. Medicaid Payment for Claims Involving a Third Party

Claims meeting the requirements for Medicaid Program payment shall be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party shall be deducted from the Medicaid allowed amount and the difference paid to the provider. If the third party payment amount exceeds the Medicaid allowed amount, the resulting Medicaid payment will be zero. Recipients may not be billed for any difference between the billed amount and Medicaid payment amount. Providers shall accept Medicaid payment as payment in full.

SECTION VII - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim will be denied. Along with a third party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number will be indicated. The provider shall pursue payment with this third party resource before billing Medicaid again.

If you have questions, please write to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, Attention: Third Party Unit, or call (800) 756-7557 (In-State) or (502) 227-2525.

SECTION VIII - COMPLETION OF INVOICE FORM

VIII. COMPLETION OF INVOICE FORM

A. General

The UB-82 (HCFA-1450) is used to bill for services rendered by a home health agency to eligible Medicaid recipients. Typing of the invoice form is strongly urged, since an invoice cannot be processed and paid unless the information supplied is complete and legible.

The original of the two part invoice set should be submitted to EDS as soon as possible after service is provided. The carbon copy of the invoice should be retained by the provider's office as a record of claim submittal.

Invoices should be mailed to:

EDS
P.O. Box 2045
Frankfort, Kentucky 40602

1. General Billing Instructions

a. The UB-82 (HCFA-1450) shall be used in billing for all covered services provided to eligible Medicaid recipients.

b. Claims for covered services shall be received by EDS within twelve (12) months from the date of service. Claims with service dates more than twelve (12) months old may be considered for processing only with appropriate documentation such as one or more of the following: Remittance Statements no more than 12 months of age which verify timely billing; backdated MAID cards with "Backdated Card" written on the attached claim; Social Security documents; correspondence describing extenuating circumstances; Action Sheets, Return to Provider Letters; Medicare Explanation of Medical Benefits, etc.

c. A single billing statement shall not include services provided in different calendar months.

d. Services provided in different fiscal years of the agency SHALL be billed on separate billing statements.

e. A separate billing statement shall be used for each recipient.

f. A separate line shall be completed for each covered home health service. A single billing statement may include charges for more than one home health service.

g. The type of bill for the home health program is 331.

h. The UB-82 (HCFA-1450) shall be completed in duplicate. The original is to be forwarded to EDS and the copy is to be retained for the agency's file.

i. The Medicaid recipient's Medical Assistance Identification Card should be examined each time home health services are provided or at least monthly to assure that the home health agency has the correct spelling of the recipient's name and the correct Medical Assistance Identification Number (MAID Number). The home health agency should ascertain that the recipient was eligible for service on the dates that the services were provided and that the name and MAID number entered on the billing statement are exactly as they appear on the current Medical Assistance Identification Card.

B. Completion of the UB-82 (HCFA-1450)

An example of a UB-82 (HCFA-1450) is shown in the appendix. Instructions for the proper completion of this form are presented below.

BLOCK NO.	ITEM DESCRIPTION
1	PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER
	Enter the complete name and address of the provider. The telephone number, including area code, is desired.
3	PATIENT CONTROL NUMBER
	Enter the patient control number assigned by the provider. The first seven digits will appear on the Remittance Statement as the invoice number.

SECTION VIII - COMPLETION OF INVOICE FORM

4 TYPE OF BILL

Enter the appropriate 3 digit code to indicate the type of bill. The type of bill for Home Health Services is 331.

8 MEDICAID PROVIDER NUMBER

Enter the provider's 8 digit provider number assigned by Kentucky Medicaid.

15 ADMISSION DATE

Enter the date on which the recipient was admitted to the Home Health Program in month, day, year sequence and in numeric format. For example: 01/03/92.

21 PATIENT STATUS CODE

Enter the appropriate 2 digit patient status code indicating the disposition of the recipient as of the "through" date in item #22.

Code Structure
01 - Discharge-Home
02 - Discharge to Hospital
03 - Discharge to Nursing Facility - NF
20 - Expired
30 - Still patient of this agency

22 STATEMENT COVERS PERIOD

Enter the "from" and "through" date in numeric month, day and year format. The billing period cannot exceed one calendar month per claim.

SECTION VIII - COMPLETION OF INVOICE FORM

28 OCCURRENCE CODES AND DATES

If the services rendered were required as the result of an accident, enter an 01 in this block; otherwise, leave blank.

44 SPECIAL PROGRAM INDICATOR

Enter an 01 if the services were provided as direct consequence of the recipient being referred to you as the result of an Early and Periodic Screening, Diagnosis and Treatment examination.

45 REFERRING PROVIDER'S MEDICAID NUMBER

Referring provider's number is required for KenPAC recipients. Enter the 8-digit Kentucky Medicaid number of the referring KenPAC provider.

50 DESCRIPTION

Enter the standard abbreviations assigned to each revenue category.

51 REVENUE CODES

Enter the 3 digit code identifying specific services. The Kentucky Medicaid Program covered revenue codes are as follows:

SERVICE	REVENUE CODE
Disposable Medical Supplies	270
Nutritional Enteral Products	279
Physical Therapy	420
Occupational Therapy	430
Speech Therapy	440
Nursing	550
Medical Social Service	560
Home Health Aide	570
Total	001

SECTION VIII - COMPLETION OF INVOICE FORM

52 UNITS

Enter the quantitative measure of services provided per revenue code.

53 TOTAL CHARGES

Enter the total charges pertaining to the related revenue codes for the billing period. The detailed amounts, by revenue codes, must equal the entry "total charges". Revenue code 001 shall be the final entry in column 53.

57 PAYER IDENTIFICATION

Enter the names of payer organizations from which the provider expects payment. All other liable payers, including Medicare, shall be billed first.

*The Medicaid Program is payer of last resort.

60 DEDUCTIBLE (MEDICARE CROSSOVER CLAIMS)

Enter the amount as shown on the Medicare EOMB to be applied to the recipient's deductible amount due. Attach Medicare Documentation.

61 CO-INSURANCE (MEDICARE CROSSOVER CLAIMS)

Enter the amount as shown on the Medicare EOMB to be applied toward the recipient's coinsurance amount due. Attach Medicare Documentation.

63 PRIOR PAYMENTS

Enter the amount the provider has received toward payment of the account prior to the billing date. Spend-down amount and third party payment shall be entered in this area. Do not enter the Medicare payment.

SECTION VIII - COMPLETION OF INVOICE FORM

65 INSURED'S NAME

Enter the insured's name in 65 A, B and C that relates to the payer in 57 A, B and C. Enter the recipient's name exactly as it appears on the Medical Assistance Identification (MAID) card in last name, first name, and middle initial format.

68 IDENTIFICATION NUMBER

Enter the insured's identification number in 68 A, B and C that relates to the insured's name in 65 A, B and C. Enter the 10 digit Medical Assistance identification number exactly as it appears on the Medical Assistance Identification (MAID) card.

77 PRINCIPAL DIAGNOSIS CODE

Enter the ICD-9-CM, Vol. 1 and 2 code describing the principal diagnosis.

78-81 OTHER DIAGNOSIS CODES

Enter the ICD-9-CM, Vol. 1 and 2 codes that co-exist at the time the service is provided.

87 PRO - MAP-34 INDICATOR

Enter a "Y" whenever a MAP-34 form has been completed in relation to the services billed on the UB-82 and is available in the recipient's record.

95 PROVIDER CERTIFICATION AND SIGNATURE

The actual signature of the provider's authorized representative is required. Stamped or typed signatures are not accepted.

96 DATE BILL SUBMITTED

Enter the date in month, day, year numeric format that the UB-82 form was completed and signed.

C. Billing Instructions for Claims with Service Dates Over 1 Year Old

Medicaid claims shall be filed within one year of the date of service. Medicaid and Medicare crossovers shall be filed within one year of the date of service OR within six months of the Medicare Adjudication Date, whichever is longer. To process claims beyond this limit you shall attach, to EACH claim form involved, a copy of an in-process or denied claim remittance, no more than 12 months of age, which verifies that the original claim was submitted within 12 months of the service date.

Copies of previously submitted claim forms, providers' in-house records of claim submittal, letters which merely detail filing dates are NOT acceptable documentation of timely billing. Attachments must prove that the claim was RECEIVED timely by EDS.

If a claim is being submitted after twelve months from the date of service, due to the recipient's retroactive eligibility, a copy of the backdated or retroactive MAID card shall be attached to the invoice.

Please note on the claim the words "Backdated Eligibility" or "Retroactive Eligibility."

SECTION VIII - COMPLETION OF INVOICE FORM

D. Electronic Media Claims (EMC)

Electronic Media Claims (EMC) is a means by which Home Health providers may submit claims electronically. EMC enables providers to experience an improved cash flow, fewer errors in claims processing, and a reduction in effort with claim preparation. Claims may be submitted electronically in a variety of different ways such as via magnetic tape, diskette, or modem.

Claims that require attachments shall not be submitted electronically.

For more information regarding EMC, contact an EMC Representative at (502) 227-2525 or 1-800-756-7557. You may also write to EDS, P.O. Box 2009, Frankfort, Kentucky 40602.

SECTION IX - REMITTANCE STATEMENT

IX. REMITTANCE STATEMENT

A. General

The EDS Remittance Statement (Remittance Advice) furnishes the provider with an explanation of the status of those claims EDS processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by the Medicaid Program with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total by the Medicaid Program with the corresponding Explanation of Benefit (EOB) code.

The third section provides a list of claims EDS received which did not complete processing as of the date indicated on the Remittance Statement.

The fourth section provides a list of claims received by EDS that could not be processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the year-to-date claims payment activities.

The sixth section provides a list of EOB codes which appeared on the dated Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the patient's last name.

B. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix IX P.1. This section lists all those claims for which payment is being made. On the pages immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT FOR
HOME HEALTH SERVICES

ITEM	DEFINITION
INVOICE NUMBER	The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference.
RECIPIENT NAME	The name of the recipient as it appears on the Department's file of eligible Medicaid recipients.
RECIPIENT NUMBER	The Medical Assistance I.D. Number of the recipient as shown on the claim form submitted by the provider.
INTERNAL CONTROL NO.	The internal control number (ICN) assigned to the claim for identification purposes by EDS.
CLAIM SVC DATE	The earliest and latest dates of services as shown on the claim form.
TOTAL CHARGES	The total charges billed by the provider for services on this claim form.

SECTION IX - REMITTANCE STATEMENT

CHARGES NOT COVRD	Any portion of the provider's billed charges that are not being paid (examples: rejected line item, reduction in billed amount to allowed charge).
AMT. FROM OTHER SRCS	The amount indicated by the provider as received from a source other than the Medicaid Program for services on the claim.
CLAIM PMT AMOUNT	The amount being paid by the Medicaid Program to the provider for this claim.
EOB	For explanation of benefit code, see back page of Remittance Statement.
LINE NO.	The number of the line on the claim being printed.
PS	Place of service code depicting the location of the rendered service.
PROC	The HCPCS procedure code in the line item.
QTY	The number of procedures or supply for that line item charge.
LINE ITEM CHARGE	The charge submitted by the provider for the procedure in the line item.
LINE ITEM PMT	The amount being paid by the Medicaid Program to the provider for a particular line item.
EOB	Explanation of benefit code which identifies the payment process used to pay the line item.

C. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists all those claims and indicates the EOB code explaining the reason for each claim rejection. Appendix IX P.2.

All items printed have been previously defined in the description of the paid claims section of the Remittance Statement.

D. Section III - Claims in Process

The third section of the Remittance Statement (Appendix IX P.3) lists those claims which have been received by EDS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of data errors or the need for further review. A claim appears in the Claims in Process section of the Remittance Statement as long as it remains in process. At the time a final determination can be made as to claim disposition (payment or rejection) the claim will appear in Section I or II of the Remittance Statement.

E. Section IV - Returned Claims

The fourth section of the Remittance Statement (Appendix IX P.4) lists those claims which have been received by EDS and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

F. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and year-to-date (YTD) claims payment activities.

CLAIMS PAID OR DENIED	The total number of finalized claims which have been determined to be denied or paid by the Medicaid Program, as of the date indicated on the Remittance Statement and YTD summation of claim activity.
AMOUNT PAID	The total amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity.
WITHHELD	The dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies)
NET PAY AMOUNT	The dollar amount that appears on the check.
CREDIT AMOUNT	The dollar amount of a refund that a provider has sent in to EDS to adjust the 1099 amount (this amount does not affect claims payment, it only adjusts the 1099 amount).
NET 1099 AMOUNT	The total amount of money that the provider has received from the Medicaid Program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds.

G. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement will have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix IX P.5).

SECTION X - GENERAL INFORMATION - EDS

X. GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

Type of Information Requested	Time Frame for Inquiry	Mailing Address
Inquiry	6 weeks after billing	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Communications Unit
Adjustment	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Adjustments Unit
Refund	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Financial Services

Type of Information Requested	Necessary Information
Inquiry	1. Completed Inquiry Form 2. Remittance Advice or Medicare EOMB, when applicable. 3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on a Remittance Advice within a reasonable amount of time.

Type of Information Requested	Necessary Information
Adjustment	1. Completed Adjustment Form 2. Corrected Claim 3. Photocopy of the applicable portion of the Remittance Advice in question
Refund	1. Refund Check 2. Cash Refund Documentation Form 3. Photocopy of the applicable portion of the Remittance Advice in question 4. Reason for refund

B. Telephoned Inquiry Information

What is Needed?

-Provider number
-Patient's Medicaid ID number
-Date of service
-Billed amount
-Your name and telephone number

When to Call?

-When claim is not showing on paid, pending or denied sections of the Remittance Advice within 6 weeks
-When the status of claims is needed and they do not exceed five in number

Where to Call?

-Toll-free number 1-800-756-7557 (within Kentucky)
-Local (502) 227-2525

C. Filing Limitations

New Claims	-	12 months from date of service
Medicare and Medicaid Crossover Claims	-	12 months from date of service
		NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.
Third-Party Liability Claims	-	12 months from date of service
		NOTE: If the other insurance company has not responded within 120 days of the date a claim is submitted to the insurance company, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.
Adjustments	-	12 months from date the paid claim appeared on the Remittance Advice

D. Provider Inquiry Form

The Provider Inquiry form should be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. (If requesting more than one claim status, a Provider Inquiry form should be completed for each status request.) The Provider Inquiry Form should be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-(800)-756-7557 or 1-(502)-227-2525.

Please remit both copies of the Provider Inquiry form to EDS. Any additional documentation that would help clarify your inquiry should be attached. EDS will enter their response on the form and the yellow copy will be returned to the provider.

It is not necessary to complete a Provider Inquiry form when resubmitting a denied claim.

Provider Inquiry forms may not be used in lieu of the Medicaid [KMAP] claim forms, Adjustment forms, or any other document required by the Medicaid Program.

In certain cases it may be necessary to return the inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry form are found on the next page.

SECTION X - GENERAL INFORMATION - EDS

Following are field by field instructions for completing the Provider Inquiry form:

Field Number	Instructions
1	Enter your 8-digit Kentucky Medicaid Provider Number.
2	Enter your Provider Name and Address.
3	Enter the Medicaid recipient's name as it appears on the Medical Assistance I.D. Card.
4	Enter the recipient's 10 digit Medicaid ID number.
5	Enter the billed amount of the claim on which you are inquiring.
6	Enter the claim service date(s).
7	If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Advice listing the claim.
8	If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13 digit internal control number listed on the Remittance Advice for that particular claim.
9	Enter your specific inquiry.
10	Enter your signature and date of the inquiry.

E. Adjustment Request Form

The Adjustment Request form is to be used when requesting a change on a previously paid claim. This does not include denied claims or claims returned to the provider for requested additional information or documentation.

For prompt action and response to the adjustment requests, please complete all items. COPIES OF THE CLAIM AND THE APPROPRIATE PAGE OF THE REMITTANCE ADVICE MUST BE ATTACHED TO THE ADJUSTMENT REQUEST FORM. If items are not completed, the form may be returned.

Field Number	Description
1	Enter the 13-digit claim number for the particular claim in question.
2	Enter the recipient's name as it appears on the Remittance Advice (last name first).
3	Enter the complete recipient identification number as it appears on the Remittance Advice. The complete Medicaid number contains 10 digits.
4	Enter the provider's name, address and complete provider number.
5	Enter the "From Date of Service" for the claim in question.
6	Enter the "To Date of Service" for the claim in question.
7	Enter the total charges submitted on the original claim.

Field Number	Description
8	Enter the total Medicaid payment for the claim as found under the "Claims Payment Amount" column on the Remittance Advice.
9	Enter the Remittance Advice date which is found on the top left corner of the remittance. Please do not enter the date the payment was received or posted.
10	Specifically state WHAT is to be adjusted on the claim (i.e. date of service, units of service).
11	Specifically state the reasons for the request adjustment (i.e. miscoded, overpaid, underpaid).
12	Enter the name of the person who completed the Adjustment Request Form.
13	Enter the date on which the form was submitted.

Mail the completed Adjustment Request form, claim copy and Remittance Advice to the address on the top of the form.

To reorder these forms, contact the Communications Unit by mail:

EDS
P.O. Box 2009
Frankfort, KY 40602

Be sure to specify the number of forms you desire. Allow 7 days for delivery.

The provider may also obtain copies of these forms by calling EDS at (502) 227-2525 or 1-800-756-7557.

F. Cash Refund Documentation

The Cash Refund Documentation form must be completed when a provider sends a refund check. The completed form and a copy of the remittance advice page showing the paid claim being refunded should accompany the check. Please mail to the following address:

EDS
P.O. Box 2009
Attn: Financial Services
Frankfort, KY 40602

If a check is sent without the Cash Refund Documentation form, your check will not be posted to a specific claim. This action would not reflect the refund being made for a particular claim, possibly leaving the provider responsible for another refund at a later date. If there are any questions concerning the form, please call the Provider Relations Unit at 1-800-756-7557 or 1-(502)-227-2525.

Field Number	Description
1	Enter check number
2	Enter amount of the check
3	Enter provider name, number and address
4	Enter name of recipient on claim being refunded
5	Enter recipient's Medicaid identification number (10 numeric digits)
6	Enter "From Date of Service" on claim being refunded
7	Enter "To Date of Service" on claim being refunded

8 Enter date of the paid Remittance Advice on which the claim appears

9 Enter 13-digit Internal Control Number (ICN) of the particular claim for which you are refunding. This is listed on the "Paid Claims" page of your remittance advice. (If several ICN's are to be applied to one check, they can be listed on the same form only if they have the same reason for refund explanation (see below).

REASON FOR REFUND

Check the appropriate reason for which the claim is being refunded. Be sure to complete all blanks. The example listed below shows how each refund is to be completed accurately. Only one reason can be completed per Cash Refund Documentation form. If multiple claims with multiple refund reasons are included in one check, complete a separate form for each refund reason.

a. Payment from other source - Check the category and list name (attach a copy of EOB)

Health Insurance
Auto Insurance
Medicare paid
Other Worker's Comp-ABC Construction

b. Billed in error

c. Duplicate payment (attach a copy of both RA's) If RA's are paid to 2 different providers specify to which provider number the check is to be applied

1 2 3 4 5 6 7 8

d. Processing error or Overpayment

Explain why: Processing error-wrong date of service was keyed

e. Paid to wrong provider

f. Money has been requested - date of letter 1-1089 (Attach a copy of letter requesting money)

g. Other

Medicare made an adjustment. Deductible no longer due.

Contact Name:

DEPARTMENT FOR MEDICAID SERVICES

ADVANCED REGISTERED NURSE PRACTITIONER SERVICES

Services by an Advanced Registered Nurse Practitioner shall be payable if the service provided is within the scope of licensure. These services shall include, however not be limited to, services provided by the certified nurse midwife (CNM), family nurse practitioner (FNP), and pediatric nurse practitioner (PNP).

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services provided in free-standing ambulatory surgical centers.

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up postnatal visits within four (4) to six (6) weeks of the delivery date.

DENTAL SERVICES

Coverage shall be limited but includes cleanings, oral examinations, X-rays, filling, extractions, palliative treatment of oral pain, hospital and emergency calls for recipients of all ages. Other preventive dental services (i.e. root canal therapy) and Comprehensive Orthodontics are also available to individuals under age twenty-one (21).

DURABLE MEDICAL EQUIPMENT

Certain medically-necessary items of durable medical equipment, orthotic and prosthetic devices shall be covered when ordered by a physician and provided by suppliers of durable medical equipment, orthotic and prosthetics. Most items require prior authorization.

EARLY PERIODIC, DIAGNOSIS, AND TREATMENT (EPSDT)

Under the EPSDT program, Medicaid-eligible children, from birth through the birth month of their twenty-first birthday may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

Medical History
Physical Examination
Growth and Development Assessment
Hearing, Dental, and Vision Screenings
Lab tests as indicated
Assessment or Updating of Immunizations

(EPSDT) SPECIAL SERVICES PROGRAM

The EPSDT Special Services Program considers medically necessary items and services that are not routinely covered under the state plan. These services are for children from birth through the end of their birth month of their twenty-first year. All services shall be prior authorized by the Department for Medicaid Services.

FAMILY PLANNING SERVICES

Comprehensive family planning services shall be available to all eligible Medicaid recipients of childbearing age and those minors who can be considered sexually active. These services shall be offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services also shall be available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, shall be available through the Family Planning Services element of the Kentucky Medicaid Program. Follow-up visits and emergency treatments also shall be provided.

HEARING SERVICES

Hearing evaluations and single hearing aids, when indicated, shall be paid for by the program for eligible recipients, to the age of twenty-one (21). Follow-up visits, as well as check-up visits, shall be covered through the hearing services element. Certain hearing aid repairs shall also be paid through the program.

HOME HEALTH SERVICES

Skilled nursing services, physical therapy, speech therapy, occupational therapy, and aide services shall be covered when necessary to help the patient remain at home. Medical social worker services shall be covered when provided as part of these services. Home Health coverage also includes disposable medical supplies. Coverage for home health services shall not be limited by age.

HOSPICE

Medicaid benefits include reimbursement for hospice care for Medicaid recipients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance shall also be provided to the patient and family in adjustment to the patient's illness and death. A Medicaid recipient who elects to receive hospice care waives all rights to certain separately available Medicaid services which shall also be included in the hospice care scope of benefits.

HOSPITAL SERVICES

INPATIENT SERVICES

Kentucky Medicaid benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions shall be preauthorization by a Peer Review Organization. Certain surgical procedures shall not be covered on an inpatient basis, except when a life-threatning situation exists, there is another primary purpose for admission, or the physician certifies a medically necessity requiring admission to the hospital. Elective and cosmetic procedures shall be outside the scope of program benefits unless medically necessary or indicated. Reimbursement shall be limited to a maximum of fourteen (14) days per admission except for services provided to recipients under age six (6) in hospitals designated as disproportionate share hospitals by Kentucky Medicaid and services provided to recipients under age one (1) by all acute care hospitals.

OUTPATIENT SERVICES

Benefits of the program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician, clinic visits, pharmaceuticals, emergency room services in emergency situations as determined by a physician, and services of hospital-based emergency room physicians.

There shall be no limitations on the number of hospital outpatient visits or covered services available to Medicaid recipients.

KENTUCKY COMMISSION FOR HANDICAPPED CHILDREN

The Commission provides medical, preventive and remedial services to handicapped children under age twenty-one (21). Targeted Case Management Services are also provided. Recipients of all ages who have hemophilia may also qualify.

LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky Medicaid participating independent laboratories includes procedures for which the laboratory is certified by Medicare.

LONG TERM CARE FACILITY SERVICES

INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED (ICF/MR/DD)

The Kentucky Medicaid Program shall make payment to intermediate care facilities for the mentally retarded and developmentally disabled for services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age twenty-two (22), who because of their mental and physical condition require care and services which are not provided by community resources.

NURSING FACILITY SERVICES

The Department for Medicaid Services shall make payment for services provided to Kentucky Medicaid eligible residents of nursing facilities which have been certified for participation in the Kentucky Medicaid Program. The need for admission and continued stay shall be certified by the Kentucky Medicaid Peer Review Organization (PRO). The Department shall make payment for Medicare deductible and coinsurance amounts for those Medicaid residents who are also Medicare beneficiaries.

The need for the ICF/MR/DD level of care shall be certified by the Kentucky Medicaid Peer Review Organization (PRO).

MENTAL HEALTH SERVICES

COMMUNITY MENTAL HEALTH CENTER SERVICES

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Psychosocial Rehabilitation
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health centers and possibly avoid hospitalization. There are fourteen (14) major centers, with satellite centers available. The Kentucky Medicaid Program also reimburses psychiatrists for psychiatric services through the physician program.

MENTAL HOSPITAL SERVICES

Reimbursement for inpatient psychiatric services shall be provided to Medicaid recipients under the age of twenty-one (21) and age sixty-five (65) or older in a psychiatric hospital. There shall be no limit on length of stay; however, the need for inpatient psychiatric hospital services shall be verified through the utilization control mechanism.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Inpatient psychiatric residential treatment facility services are limited to residents age six (6) to twenty-one (21). Program benefits are limited to eligible recipients who require inpatient psychiatric residential treatment facility services on a continuous basis as a result of a severe mental or psychiatric illness. There is no limit on length of stay; however, the need for inpatient psychiatric residential treatment facility services must be verified through the utilization control mechanism.

TARGETED CASE MANAGEMENT SERVICES

ADULTS Case management services are provided to recipients eighteen (18) years of age or older with chronic mental illness who need assistance in obtaining medical, educational, social, and other support services.

CHILDREN Case management services are provided to Severely Emotionally Distrubed (SED) children who need assistance in obtaining medical, educational, social, and other services.

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist shall be covered by the Kentucky Medicaid Program.

NURSE MIDWIFE SERVICES

Medicaid coverage shall be available for services performed by and within the scope of practice of certified registered nurse midwives through the Registered Nurse Practitioner Program.

PHARMACY SERVICES

Legend and non-legend drugs from the approved Medical Assistance Outpatient Drug List when required in the treatment of chronic and acute illnesses shall be covered. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and providers upon request and routinely sent to participating pharmacies and nursing facilities . The Drug List is distributed periodically with monthly updates. Certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization shall be covered for payment through the Drug Preauthorization Program.

In addition, nursing facility residents may receive other drugs which may be prior authorized as a group only for nursing facility residents.

PHYSICIAN SERVICES

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, selected vaccines and RhoGAM, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms shall be completed prior to coverage of these procedures.

Non-covered services include:

Most injections, supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

Certain types of office exams, e.g. new patient comprehensive office visits, shall be limited to one (1) per twelve (12) month period, per patient, per physician.

PODIATRY SERVICES

Selected services provided by licensed podiatrists shall be covered by the Kentucky Medicaid Program. Routine foot care shall be covered only for certain medical conditions where the care requires professional supervision.

PREVENTIVE HEALTH SERVICES

Preventive Health Services shall be provided by health department or districts which have written agreements with the Department for Health Services to provide preventive and remedial health care to Medicaid recipients.

PRIMARY CARE SERVICES

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits shall be generally applicable when the services are provided by a primary care center.

RENAL DIALYSIS CENTER SERVICES

Free-standing renal dialysis center benefits include renal dialysis, certain supplies and home equipment.

RURAL HEALTH CLINIC SERVICES

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasized preventive and maintenance health care for people of all ages. The clinics, though physician directed, shall also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

TRANSPORTATION SERVICES

Medicaid shall cover transportation to and from Medicaid Program covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered shall be preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services when provided by a participating medical transportation provider. Travel to pharmacies shall not be covered.

VISION SERVICES

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists shall be covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs shall be covered for eligible recipients under age twenty-one (21).

DEPARTMENT FOR MEDICAID SERVICES

SPECIAL PROGRAMS

ALTERNATIVE INTERMEDIATE SERVICES FOR THE MENTALLY RETARDED

The Alternative Intermediate Services for the Mentally Retarded (AIS/MR) home- and community-based services project provides coverage for an array of community based services that shall be an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD).

HOME AND COMMUNITY BASED WAIVER SERVICES

A home-and community-based services program provides Medicaid coverage for a broad array of home-and community-based services for elderly and disabled recipients. These services shall be available to recipients who would otherwise require the services in a nursing facility. The services became available statewide effective July 1, 1987. These services shall be arranged for and provided by home health agencies.

KenPAC

The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only shall be covered under KenPAC. The recipient shall choose the physician or clinic. It is especially important for the KenPAC recipient to present his or her Medical Assistance Identification Card each time a service is received.

SPECIAL HOME-AND COMMUNITY-BASED SERVICES MODEL WAIVER PROGRAM

The Model Waiver Services Program provides up to sixteen (16) hours of private duty nursing services and respiratory therapy services to disabled ventilator dependent Medicaid recipients who would otherwise require the level of care provided in a hospital-based skilled nursing facility. This program shall be limited to no more than fifty (50) recipients.

ELIGIBILITY INFORMATION

Programs

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

AFDC (Aid to Families with Dependent Children)

AFDC Related Medical Assistance

State Supplementation of the Aged, Blind or Disabled

Aged, Blind, or Disabled Medical Assistance

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits shall be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office of information about making application. Form most program, a relative or other interested party may make application for a person unable to visit the office.

In addition to the program administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) programs also receive Medicaid through the Medicaid Program, Eligibility for SSI is determined by the Social Security Administration. Persons wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live: The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

ELIGIBILITY INFORMATION

MAID Cards

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one (1) MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID cards may show a retroactive period eligibility. Depending on the individual circumstances of eligibility, the retroactive period may include several months.

Duplicate MAID cards may be issued for individuals who original card is lost or stolen. The recipient shall report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

Verifying Eligibility

The local Department for Social Insurance, Division of Field Services staff may provide eligibility to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-A

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

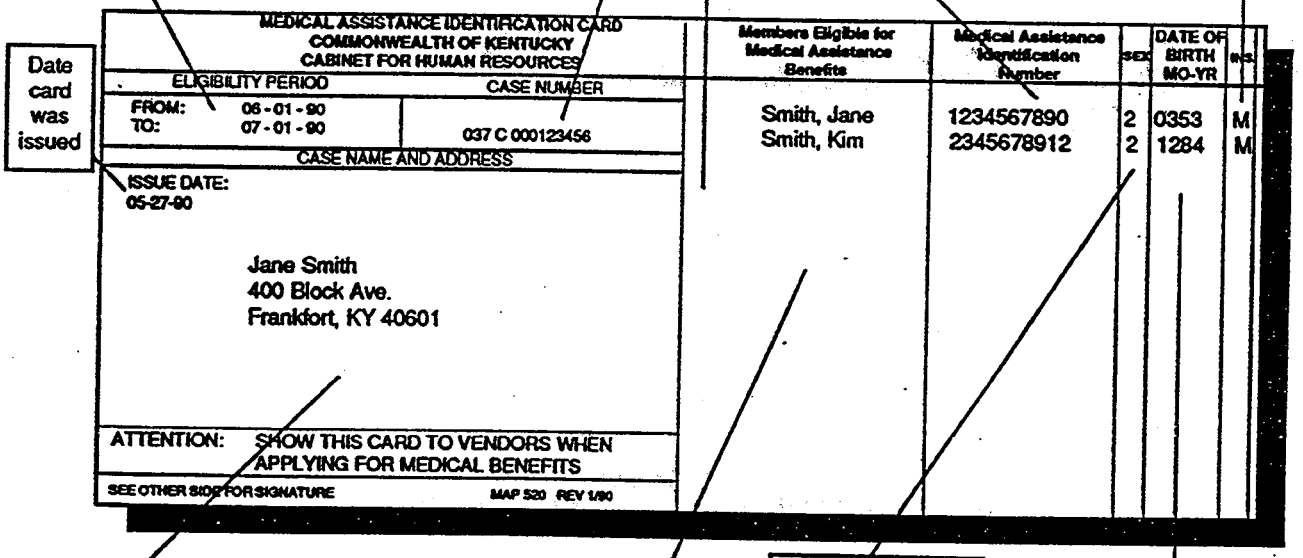
(FRONT OF CARD)

Eligibility period is the month, day and year of Kentucky Medicaid eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.



MEDICAL ASSISTANCE IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ELIGIBILITY PERIOD
FROM: 06-01-90
TO: 07-01-90

CASE NUMBER
037 C 000123456

CASE NAME AND ADDRESS

ISSUE DATE:
05-27-90

Jane Smith
400 Block Ave.
Frankfort, KY 40601

ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS

SEE OTHER SIDE FOR SIGNATURE

MAP 520 REV 1/90

Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	SEX	DATE OF BIRTH MO-YR	M/S
Smith, Jane	1234567890	2	0353	M
Smith, Kim	2345678912	2	1284	M

Date card was issued

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For Kentucky Medicaid Program Statistical Purposes

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

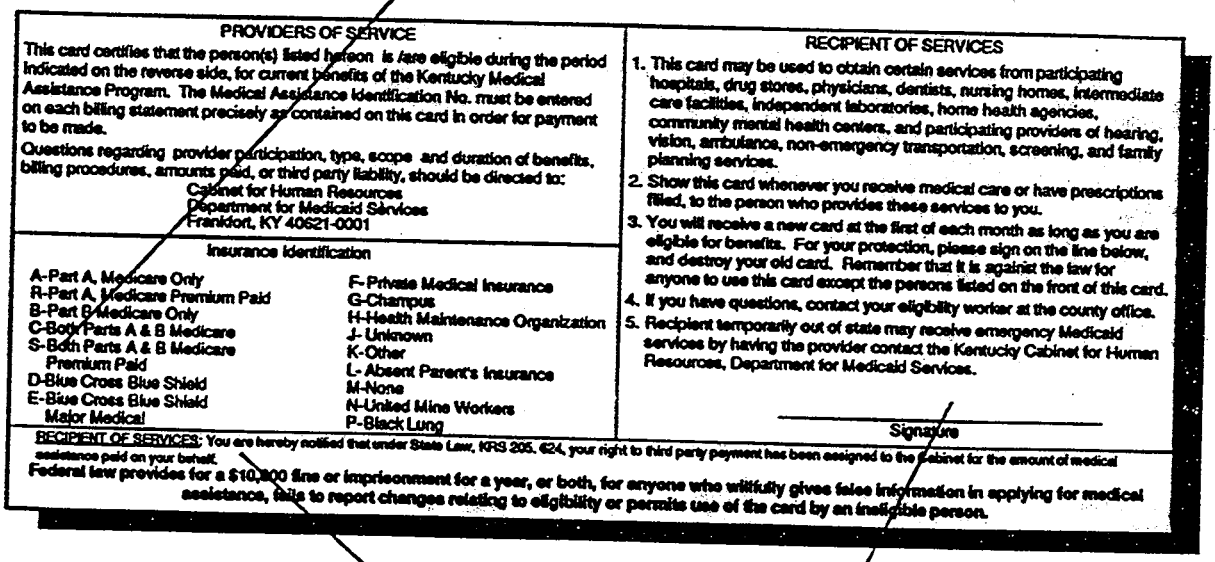
Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for Kentucky Medicaid Program benefits.

WHITE CARD

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers. Insurance identification codes indicate type of insurance coverage as shown on the front of the card in "Ins." block.



PROVIDERS OF SERVICE

This card certifies that the person(s) listed hereon is/are eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:
Cabinet for Human Resources
Department for Medicaid Services
Frankfort, KY 40621-0001

Insurance Identification

A-Part A, Medicare Only
R-Part A, Medicare Premium Paid
B-Part B Medicare Only
C-Both Parts A & B Medicare
S-Both Parts A & B Medicare Premium Paid
D-Blue Cross Blue Shield
E-Blue Cross Blue Shield Major Medical
F-Private Medical Insurance
G-Champus
H-Health Maintenance Organization
J-Unknown
K-Other
L-Absent Parent's Insurance
M-None
N-United Mine Workers
P-Black Lung

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

II. THE REQUEST PROCEDURE

A. Initiating a Request

1. Requests for pre-authorization may be initiated by the prescribing physician or office personnel under his direct supervision. Requests from pharmacists and social workers who are working directly with the recipient's physician shall also be accepted.

2. The primary concern is that the caller have available the information necessary for staff to make an accurate determination.

B. Transmittal Methods

1. Written Requests

The drug pre-authorization may be made **IN WRITING** TO: EDS, PO BOX 2036, Frankfort, Kentucky 40602.

2. Telephone Requests

Or by PLACING A TELEPHONE CALL to the following toll-free number between 8:00 a.m. and 4:30 p.m. EST/EDST, on Monday through Friday (except during holidays):
Telephone Number: 1-800-756-7558
Out of State: (502) 227-9073

III. INFORMATION REQUIRED FOR A DETERMINATION

Persons requesting a pre-authorization of medications shall provide information, line for line from the Preauthorization Request Form. Special attention should be given to giving a specific statement, indicating the need for the requested drug as well as previous medications tried unsuccessfully.

IV. DISPOSITION OF REQUEST

A. Nurses shall review each request and make determinations on the basis of established Program criteria. Extenuating circumstances shall be directed to the medical consultant.

B. If the appropriate information is received and the medication meets the Program criteria, an approval shall be made. However, if the request does not meet the basic criteria or if insufficient or contradictory information is provided, the request shall be disapproved. Drug Preauthorization staff will NOT assume responsibility for calling physicians for more information.

C. Unusual or unique situations shall be reviewed by consultant pharmacists, physicians, and recognized University staff.

D. When the medication is not on the DMS Drug List and is disapproved for pre-authorization, the recipient shall assume responsibility for the cost or obtain an alternative source of payment.

E. Determinations shall be made daily Monday through Friday, except on holidays.

V. NOTIFICATION OF DISPOSITION

A. Notification regarding the disposition (approval or disapproval) of each pre-authorization request shall be made as follows:

1. **DISAPPROVALS:** When disapproved, the prescribing physician shall be notified by mail. The request and reason for disapproval shall be provided.

2. **APPROVALS:** When approved, notification shall be made by phone to the selected pharmacy. The pharmacist shall provide the pre-authorization staff with the NDC number and provider number.

NOTE: Pre-authorization shall not be guaranteed for any request until reviewed and approved by pre-authorization staff members. If any change should occur, i.e. NDC#, MAID#, quantity, etc., please notify pre-authorization staff immediately to assure Program payment.

B. Period of Coverage

The effective date for Program coverage of preauthorized drugs shall begin on the date the request is postmarked or date received by phone. The pre-authorization shall remain in effect for the specified time on the "Authorization to Bill" or until the recipient becomes ineligible, whichever comes first.

CAUTION: Pre-authorization does not guarantee payment.
Recipient shall be eligible on date of service.
Verify by checking the recipient's Medicaid card.

VI. PHARMACY INFORMATION

A. Reimbursement for Preauthorized Drugs

1. Selected pharmacies shall be reimbursed at the lower of the MAC, if applicable, or Average Wholesale Price (AWP) minus ten (10) percent plus dispensing fee, or usual and customary charge to the general public.

2. Private insurance companies and Medicare, if applicable, **SHALL BE BILLED PRIOR** to submitting claims for payment.

B. Pharmacy Billing for Preauthorized Drugs

Preauthorized drugs shall be billed in the same manner as drugs on the Kentucky Medicaid Outpatient Drug List -- utilizing regular pharmacy billing statements notating the pre-authorization number in the appropriate field.

C. Payment Inquiries

If pharmacies have any questions regarding payment for submitted preauthorized drugs, EDS should be contacted at 1-800-756-7557 or at EDS, PO BOX 2009, FRANKFORT KY 40602.

VII. ADDITIONAL INFORMATION

Any questions regarding the Drug Preauthorization Procedure shall be directed to:

EDS
PO BOX 2036
FRANKFORT KY 40602

Telephone Number: 1-800-756-7558

equester: Please complete outlined fields.
harmacist: Please complete other fields marked by an asterisk. *

Date:____________

Kentucky Medical Assistance Program

Drug Prior Authorization/Authorization To Bill

Mail to:
EDS
P.O. Box 2036
Frankfort, KY
40602

Patient's Name: ____________

MAID # ____________

Pharmacy Name: ____________

* Address: ____________

* City/St./Zip: ____________

Physician Name: ____________

Address: ____________

City/St./Zip: ____________

* Pharmacy Provider No.: _ _ _ _ _ _ _ _

Prescribing Physician License Number _ _ _ _ _ _

Phone: (   ) ____________

Phone: (   ) ____________

PA Number | Drug Name | NDC * _ _ _ _ _ 0 _ _ _ _

Strength | Quantity | Begin Date * | End Date

Diagnosis

Other Drugs Tried Without Positive Results

Notes

PA Number | Drug Name | NDC * _ _ _ _ _ 0 _ _ _ _

Strength | Quantity | Begin Date * | End Date

Diagnosis

Other Drugs Tried Without Positive Results

Notes

PA Number | Drug Name | NDC * _ _ _ _ _ 0 _ _ _ _

Strength | Quantity | Begin Date * | End Date

Diagnosis

Other Drugs Tried Without Positive Results

Notes

CAUTION: THE ABOVE RECIPIENT MUST BE ELIGIBLE ON THE DATE OF SERVICE. VERIFY BY CHECKING THE RECIPIENT'S MEDICAID CARD.

OFFICE USE ONLY

PPROVED

__________ Drug is of type already covered on KMAP Formulary.
__________ Drug is to be used in accordance with FDA standards and indications.
__________ Drug is rated "possibly or less than effective" by the FDA.
__________ Other

PRIOR AUTHORIZATION REQUEST 1-800-756-7558

Medical Policy Unit

MAP-248
(Rev. 2/88)

APPENDIX XIII

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

Home Health Program

Agency Name _____ Vendor #_____

Agency Address _____

CERTIFICATION FOR DISPOSABLE MEDICAL SUPPLIES

Patient's Name _____ MAID # _____

Address_____ Medicare #_____

_____ Birthdate _____

Other Insurance _____

Diagnosis _____

_____

_____

This is to certify that the following medical supplies are essential to meet the medical needs of this recipient.

(Indicate Directions for Use of the Supplies) _____

_____

_____

_____

_____

Anticipated Duration of Need: _____ 0-30 days _____ 1-6 months

_____ Lifetime _____ Indefinite

_____ _____
Date Physician's Signature

_____
Address

_____
License #

Must be signed and dated by the physician.

MAIL TO: EDS
P.O. BOX 2009
FRANKFORT, KY 40602

APPENDIX XIV

CASH REFUND DOCUMENTATION

1. Check Number _____

2. Check Amount _____

3. Provider Name/Number/Address

4. Recipient Name _____

5. Recipient Number _____

6. From Date of Service _____

7. To Date of Service _____

8. RA Date _____

9. Internal Control Number (If several ICNs attach RAs)

__|__|__|__|__|__|__|__|__|__|__|__|__|

Reason for Refund: (Check appropriate blank)

___ a. Payment from other source - Check the category and list name (attach a copy of EOB)
- ___ Health Insurance
- ___ Auto Insurance
- ___ Medicare paid
- ___ Other _____

___ b. Billed in error

___ c. Duplicate payment (attach a copy of both RA's)
If RA's are paid to 2 different providers specify to which provider number the check is to be applied.

_ _ _ _ _ _ _ _ _

___ d. Processing error OR Overpayment

Explain why _____

_____

___ e. Paid to wrong provider

___ f. Money has been requested - date of the letter __/__/__
(Attach a copy of letter requesting money)

___ g. Other _____

_____

Contact Name _____ Phone: _____

Case Management Protocol
Home Apnea Monitoring

Kentucky Medical Assistance Program
Department for Social Insurance
Cabinet for Human Resources

June 18, 1984

Michigan Department of Public Health
Case Management Protocol for Medical and Nursing Care
of the Home Apnea Monitored Child was used as a guide

REPORT
MEDICAL ASSISTANCE ADVISORY COUNCIL

Special Committee for
Home Apnea Monitoring

Attached is a final draft copy of the case management protocol for Home Apnea Monitoring.

The special committee to review the protocol related to apnea/bradycardia home monitoring met Tuesday, May 15, 1984, as requested by the Kentucky Medical Assistance Advisory Council at its regular meeting of March 7, 1984.

Ms. Janet Rodgers, L.P.T., with the Visiting Nurse Association of Louisville, Kentucky, served as chairperson for the committee. Also serving on the committee and in attendance at the meeting were the following people:

Doane Fischer, M.D., Department of Pediatrics, University of Kentucky Medical Center, Lexington, Kentucky
John Roberts, M.D., Neonatologist, Department of Pediatrics, Kosair-Childrens Hospital, Louisville, Kentucky
Patricia K. Nicol, M.D., Director, Division of Maternal and Child Health, Department for Health Services
Joy Davis, R.N., Continuity of Care Coordinator, Kosair-Childrens Hospital, Louisville, Kentucky
Maggie Murray, R.N., Administrator, St. Claire Medical Center Home Health Agency, Morehead; Kentucky
Ida Lyons, Program Coordinator, Sudden Infant Death Syndrome Program, Division of Maternal and Child Health

Additional people in attendance were:

Nileen Verbeten, Executive Director, Kentucky Home Health Association
Fletcher Lutcavish, Assistant Director, Division of Medical Assistance, Department for Social Insurance
Jean Farrisee, Supervisor, Alternate Care Section, Division of Medical Assistance
Peggy Nelson, R.N., Medical Policy Analyst, Electronic Data Systems Federal
Barbara Knox, Program Coordinator, Home Health Services, Division of Medical Assistance

In developing this protocol, the committee considered recent data available on home apnea monitoring as well as using the expertise of the members of the committee.

The committee recommended that the KMAP follow the guidelines of this protocol in determining reimbursement and approving home apnea monitoring. The committee would welcome the use of this protocol by groups associated with and interested in home apnea monitoring.

The committee felt strongly that home monitoring must be a) preceded by a 24-48 hour period of hospitalization for evaluation and diagnostic workup, b) coordinated prior to discharge, c) followed-up with criteria established, and d) discontined when the monitor is no longer medically necessary.

The pneumogram testing could presently be reimbursed as a nospital inpatient or outpatient service.

The committee recognized that at the present time, however, there is no KMAP coverage for the pneumogram testing and evaluation provided in the patient's home. Since this may be necessary in determining the appropriateness of discontinuing the monitor, the committee strongly recommends that coverge be made available for the pneumogram and interpretation provided in the home. Timely discontinuation of the monitor has the potential of saving the KMAP money which would otherwise be billed as rental for a prolonged length of unnecessary service.

/pp

The protocol is the product of a Special Committee convened in May 1984 at the request of the Kentucky Medical Assistance Advisory Council to provide advice and guidelines on the current state of knowledge and practice in the utilization of apnea monitors. The Committee was organized because the Home Health Technical Advisory Committee recognized the need to develop appropriate standards and policies regarding the utilization of Apnea/bradycardia monitors in order to assure quality and safe care to Medicaid recipients.

Case Management Protocol
Home Apnea Monitoring
Kentucky Medical Assistance Program
Department for Social Insurance
Cabinet for Human Resources

Introduction

THE PURPOSE OF THIS PROTOCOL is to communicate the optimal components of service for children suspected of having apnea. The protocol will be utilized by the Kentucky Medical Assistance Program (KMAP) in approving requests for financial reimbursement for apnea bradycardia monitors.

Protocol

I. MEDICAL CRITERIA FOR APNEA DIAGNOSTIC WORK-UP AND PLACEMENT OF HOME MONITORS

A. Definition of Apnea: The American Academy of Pediatrics Task Force on Prolonged Apnea defines prolonged apnea as "cessation of breathing for 20 seconds or longer, or as a briefer episode associated with bradycardia, cyanosis or pallor."

B. Etiology: Etiology includes but is not limited to seizure disorders, severe anemia, gastro-esophageal reflux, hypoglycemia, other metabolic disorders and impaired regulation of breathing.

C. Population at Risk

- Child with observed apneic episode (without demonstrable cause)
- Child with history of apnea, cyanosis, birth asphyxia or hypoxia of any cause
- Siblings of SIDS infant
- Premature infant less than 1500 grams
- Infant of drug dependent mother
- Child with tracheostomy
- Selected children with certain cardiac arythemias
- Children with specific seizure disorders

D. Elements of Diagnostic Work-Up[1]

1. REQUIRED elements of study

- History and physical examination
- Laboratory studies
  - CBC
  - Urinalysis
  - Chem 6 - (Sodium, Potassium, CO_2, BUN, Glucose, Chloride)
  - Calcium
  - Magnesium
  - Creatinine
- Cardio-respiratory monitoring (inpatient) for 24-48 hour with close professional observation of child
- Chest x-ray
- EKG

[1]If the capability for proper testing/analysis is unavailable, we recommend appropriate referral or consultation

2. Recommended further studies as indicated

- Pneumogram
- EEG
- Blood/septic work-up
- Upper GI
- Spinal tap/lumbar puncture
- CT Scan

E. Criteria for Monitor Placement

1. Presence of one or more

- Documented episode(s) of apnea with no treatable cause or an inadequate response to treatment
- Documented episode of apnea with bradycardia, cyanosis or pallor
- History of apnea described by parent or caretaker based on physician's best informed judgement and evaluation of testing
- Abnormal ventilatory pattern on pneumogram
- SIDS sibling
- Multiple-birth SIDS survivor(s)
- Potential for airway obstruction

2. Monitor order and need for monitor must be included as part of physician's order/information on Home Health Plan of Treatment recertification

F. Criteria for Continuation

- Child should be seen at least every 2 months by the primary care physician or apnea consultant after monitor placement for medical evaluation and recertification for continuing need of monitor or discontinuation
- The physician ordering and recertifying the need for the monitor must not be affiliated with the company supplying the monitor

G. Criteria for Discontinuation of the Monitor

- No clinical apnea for 2 months unless sibling of SIDS. For sibling of SIDS should leave monitor for 2 months longer than number of months of life of SIDS
- Parent preparation and readiness
- Clinical judgement

II. HOSPITAL DISCHARGE PLANNING

The following items are the responsibility of the hospital staff under the direction of the physician ordering the monitor. All activities must be completed and documented in the child's record prior to discharge.

A. Assessment

- Parent(s)[2] ability, acceptance and understanding of the purposes, responsibilities, risks and benefits of home monitoring
- Appropriateness of home environment
- Family support systems and coping abilities
- Financial ability to support home care costs, including utilities

B. Equipment (supplied to parents prior to discharge)

- Apnea and bradycardia monitor[3] which has been used by the infant for a minimum of 24 hours prior to hospital discharge
- Two sets of connecting equipment appropriate for the monitor (leads, belts, tabs, etc.)
- Power failure alarm (if not incorporated into monitor)
- Observation and incident record sheets

C. Teaching (includes instruction, discussion, demonstration of and the return demonstration by parents)

- Placement of equipment
- Attachment of monitor to child
- Operation of monitor, including setting alarm sensitivity
- Reading and interpretation of alarm
- Response sequence to monitor alarm
- Infant resuscitation techniques (use of mouth-to-mouth and CPR)
- Recording of necessary information on forms
- Emergency support plan, including names and phone numbers for:
  - Hospital emergency room
  - Key hospital staff
  - Physicians
  - Emergency squad or ambulance
  - Power company
  - Medical equipment company for monitor malfunction or failure
  - Home health agency nurse
  - Child care person
  - Transportation to hospital
- Safety measures
  - Proper grounding
  - Access to telephone
  - Available flashlight
  - Noise control
  - Close supervision of young siblings
  - Instruction to older siblings
  - Secure placement of monitor

[2] Parent(s) refers throughout to parent or caretaker.
[3] This excludes the use of pad type monitors.

D. Written Instructions (to be sent home with parents and to be attached to all home health agency referrals)

- All items in II-C (Teaching and Instruction) above

E. Physician referral

- The physician must contact the Home Health Agency and establish a Home Health Plan of Treatment to order the monitor and nursing visit(s).[4] The Home Health Agency should work in close collaboration with the physician and hospital personnel in contacting the medical equipment company and making arrangements for the equipment.[5]
- Primary care physician (unless already the ordering physician).

F. Community Referrals

- Financial aid
- Social services
- Parent support groups
- Mental health

III. COMMUNITY SERVICES

A. Responsibilities of Home Health Agency Nurse

1. Collaborate with hospital staff to assure continuity of coordinated care between hospital and home
2. Contact with child and family within 24 hours of hospital discharge
3. Assess, review and reinforce all items in II-A through D page 5-7
4. Review physical care needs of child with parent(s)
5. Assist in identifying additional resources (especially for relief) as needed
6. Review and support the child's normal growth and development with special emphasis on incorporating the child into the normal family structure
7. Review plans for follow-up care and coordinate community referrals

[4]Every child discharged with a monitor will be referred to a home health agency prior to discharge. Contact should occur between the home health agency and the hospital discharge planner to discuss specific patient care needs.

[5]Equipment should be delivered and appropriate aspects of the emergency plan reviewed with the parent(s) prior to discharge.

8. Review and report pertinent findings to the primary care physician or apnea physician consultant at a minimum of every 2 months, i.e. number of spells of apnea; how long lasted; description of spell; condition of patient during spell; was CPR/gentle shaking required, how long since last spell, etc.

9. Prepare family for eventual discontinuation of monitor

10. Offer emotional support to family and be cognizant of typical parental reactions

B. Responsibilities of Medical Equipment Suppliers

1. Collaborate with hospital staff and home health agency to assure continuity of services between hospital and home

2. Provide appropriate equipment and related supplies

3. Machine operation

   a. Review machine operation with parent(s) and supply written instructions
   b. Evaluate equipment in home within first week, i.e. written report to physician and home health nurse

4. Maintain equipment

5. Review appropriate aspects of emergency plan with parent(s)

6. 24 hour answering service and respond to calls regarding monitor malfunction or failure in timely manner

C. Responsibilities of Primary Care Physicians/Apnea Physician Consultants

1. Initiate necessary referrals

2. Primary care physician and apnea physician consultant (if applicable) should coordinate patient's care.

3. Provide ongoing education to parents regarding the pathology underlying the child's apnea and regarding eventual discontinuation of monitor

4. Provide emotional support

5. Child's progress should be evaluated by consultant or primary care physician at a minimum of every 2 months after placement of monitor

6. Review the history of apnea and daily log of the child's status

7. Review laboratory results

8. Evaluate blood levels of prescribed medication (i.e. Theophylline, Phenobarbital, etc.)

9. Discontinuation of monitor with appropriate explanation to family

Case Management Protocol for Care of the Home Ventilation Patient

Kentucky Medical Assistance Program
Department for Social Insurance
Cabinet for Human Resources

The protocol is the product of a Special Committee convened at the request of the Kentucky Medical Assistance Advisory Council to provide advice and guidelines on the current state of knowledge and practice in the care of the home ventilation patient. The Committee was organized because the Home Health Technical Advisory Committee recognized the need to develop appropriate standards and policies regarding the care of the home ventilation patient in order to assure quality and safe care to Medicaid recipients.

Case Management Protocol
for Care of the
Home Ventilation Patient
Kentucky Medical Assistance Program
Department for Social Insurance
Cabinet for Human Resources

Introduction

THE PURPOSE OF THIS PROTOCOL is to communicate the optimal components of managing the ventilator dependent patient at home. The protocol will be utilized by the Kentucky Medical Assistance Program (KMAP) in approving requests for financial reimbursement for mechanical ventilators.

The placement and care of the ventilator dependent patient involves a partnership among the physician, hospital, home health agency and equipment supplier. Because of the importance of ongoing patient care in the home setting and necessity of reliable response systems, the referring hospital/ physician shall consult with the home health agency prior to any selection of equipment supplier.

I. Eligibility Criteria

The following criteria must be met for a patient to be considered for a home ventilation program. If all criteria are not met, a home ventilator shall not be installed.

A. Medical

Candidates to be considered for a home ventilation program shall be medically stable, possess a permanent tracheostomy (for positive pressure ventilation), and be generally included in, but not limited to, the following categories:

1. Injuries of the spinal cord
2. Irreversible neuromuscular disease
3. Sleep disorders
4. Chronic pulmonary disorders
5. Other neurological disorders

A person trained in the care of patients who require mechanical ventilation, (e.g., pulmonologist, neonatologist, intensivist, cardio thoraric surgeon, internist) should review the need for at home mechanical ventilation before institution.

B. Social - Environmental

1. The patient's family/primary caregiver must be capable of comprehension and performance of duties and responsibilities relative to ventilatory dependent patient care.
2. There shall be documentation of caregiver's competence in performance of patient care.
3. There shall be documentation of acceptable dwelling and physical facilities.

C. Community Resources

1. Emergency Medical Service.
2. Local physician to accept patient when applicable.
3. Home Health Agency (with staff trained in care of ventilator dependent patients).
4. Medical equipment supplier (with staff trained in care of ventilator dependent patients).

II. Home Ventilator Plan

The following are activities necessary for adequate ventilator dependent care. When specific behavioral objectives are stated, they must be met during the course of orientation, instruction, and treatment (unless indicated as optional by an *). The responsibilities for performance of duties to the left according to the following:

HO - hospital from which patient will be discharged to home;
HH - home health agency operating within county of patient's residence;
D - durable medical equipment supplier.

In case of dual responsibilities, the agency listed first shall assume responsibility for implementation.

A. Assessment

HO/HH 1. Primary caregivers shall possess the ability to accept and understand the purposes, responsibilities, risks, and benefits of home ventilator therapy.

D/HH 2. Documented assessment of an adequate home environment shall be made prior to discharge to evaluate the following:

a. Electrical capability

b. Size of doorways and rooms

c. Accessibility (steps, ramps, etc.)

d. Bathroom location

e. Availability of telephone

f. Adequate heating and cooling

g. Adequate refuse disposal

h. Acceptable area for supplies, equipment, and exercise

HO/HH 3. Adequate family support systems and coping mechanisms shall be evaluated.

HO/HH 4. There shall be adequate financial resources to support medical, home care, nutritional, utilities, and continued family living costs.

B. Implementation

HO 1. The physician shall write the orders for home ventilation.

HO 2. The caregiver shall be instructed in the following:

HO a. Anatomy and Physiology

HO/HH b. Nutrition and Hydration

HO/HH c. Personal Care

HO/HH d. Tracheostomy Care

- site care
- dressing/ties/changing
- tube cleaning/changing/insertion
- emergency care

HO/D e. Suction Procedures

- hyperinflation/hyperoxygenation with manual ventilator (e.g., ambu bag)
- proper tracheal and nasopharyngeal suction techniques (to include sterile technique)
- installation of bland or medicated solution for secretion removal

HO f. Chest Physiotherapy

- percussion/postural drainage
- breathing retraining

HO g. Physical Therapy

- musculoskeletal exercise program
- aerobic retraining program

D/HH/HO h. Ventilator Operation

- circuit change
- equipment cleaning/disinfection
- checking and changing parameters
- checking alarm system
- safety precautions
- checking and charging electrical back-up
- trouble shooting

HO/D i. Tracheostomy Collar

- humidifier/nebulizer operation
- cleaning/disinfection
- proper FIO_2 setting
- over hydration precautions
- tubing changes
- maintenance of sterile/clean system

HO j. Cardiopulmonary Resuscitation

HO/D k. Safety Precautions

- adequate grounding
- response to alarms
- response to power failure
- response to machine failure
- recognition of early signs of respiratory distress
- response to airway occlusion
- prevention of barotrauma
- prevention of infection
- noise control
- recognition of gastric distention
- supervision of small children

HO/HH l. Medications

- name
- dosages
- frequencies
- actions
- common side effects and rationale for notification of M.C. or home health agency
- contraindications

Note: All instructions given to caregiver and patient shall be accompanied by a written procedure statement, and attached to home health referral.

C. Specific Duties

In addition to the above, those agencies and individuals shall have the following specific responsibilities:

1. Home Health Agency

a. Collaborate with hospital staff and equipment suppliers to assure continuity of coordinated care between hospital and home.

b. Organize one site visit with patient and family/ caregiver prior to discharge.

c. Be physically present upon arrival at home.

d. Assess, review, and reinforce all items included in II - A and B after discharge.

e. Assess and assist in identifying additional resources (especially respite) as needed.

f. Encourage incorporation of patient into routine family structure and lifestyle as much as possible.

g. Review follow-up plans and coordinate community referrals.

h. Assist caregivers/family in arranging six month revaluation by discharging physician or his designee.

i. Have in place twenty-four hour call system.

j. Report all pertinent findings to primary care physician as needed or every two months.

k. Assist with arranging transportation as needed and medically necessary.

l. Make changes in ventilator parameters as ordered, with immediate notification to the medical equipment suppliers.

m. Provide other supplies not available from supplier or included in ventilator units.

2. Medical Equipment Supplier

a. Supply a ventilator available for patient to use 7 to 14 days prior to discharge.

b. Maintain accurate documentation of ventilator parameters.

c. Make changes in ventilator parameters as ordered with immediate verbal and written notification to the home health agency.

d. Provide supplies necessary as ventilator adjuncts to assure complete ventilator operation.

e. Provide twenty-four hour call with one hour response for equipment repair or replacement.

f. Maintain available services of a respiratory therapist or respiratory therapy technician as identified by the National Board of Respiratory Care.

g. Provide twenty-four hour electrical source.

h. Provide manual ventilator source (with or without supplemental oxygen as ordered).

i. Perform routine maintenance as specified by manufacturer or company protocol and assure proper equipment function.

j. Provide functionally safe alarm systems.

k. Provide personnel and equipment for transport of patient from hospital.

l. Visit patient a minimum of every week during the first month and monthly after the initial month.

m. Review cleaning/sterilization techniques with caregiver.

n. Provide home health patient with written instructions/trouble shooting guide.

o. Reinforce knowledge of generator operations with caregiver and provide written guide for patient.

p. Provide written notification of presence of ventilator patient to area electric, fire and telephone services.

3. Physician

a. The discharging physician shall write all ventilator orders and discharge orders. These shall be communicated to the primary care (community) physician where applicable.

b. The discharging physician will provide period six month case review (or assign to another physician, e.g., primary care physician).

c. The primary care physician may assume total patient care which may include or exclude six month care review, at the discretion of the discharging physician.

Case Management Protocol
In-Home IV Therapy
Kentucky Medical Assistance Program
Department for Social Insurance
Division of Medical Assistance

Case Management Protocol
In-Home IV Therapy
Kentucky Medical Assistance Program
Department for Social Insurance
Cabinet for Human Resources

Introduction

THE PURPOSE OF THIS PROTOCOL is to communicate the optimal components of managing the patient receiving IV Therapy at home. The placement and care of the patient involves a partnership among the physician, hospital, home health agency, pharmacist and supplier. Because of the importance of ongoing patient care in the home setting and necessity of reliable response systems, the referring hospital/physician shall consult with the home health agency prior to any selection of supplier.

Case Management Protocol
In-Home IV Therapy
Kentucky Medical Assistance Program
Department for Social Insurance
Cabinet for Human Resources

Introduction

The purpose of this protocol is to identify the basic components of intravenous therapy and to establish criteria and guidelines for safe institution, maintenance and termination of IV Therapy in the home setting.

I. DEFINITION

Intravenous therapy is the administration of fluids, medication and/or nutritional products via the venous route and all those processes involved with its institution, maintenance and termination.

SECTION A

II. IV FLUID REPLACEMENT IN THE HOME

A. Medical Criteria

1. Inability of patient to take adequate nutritional products orally.

2 Physical signs of dehydration.

3. Baseline laboratory data with appropriate periodic evaluation and laboratory screening. Baseline laboratory data should include: WBC and differential, Hgb and/or Hct, BUN, Glucose and electrolytes. Other tests are to be done as indicated by the patients condition or diagno-

4. Safety of the IV fluids for home administration.

5. Patient in clinically stable condition; exception for terminal illness with voluntary consent of patient and/or caregiver.

6. Approved by a physician and seen by his/her agent (i.e. home health nurse) in the preceding 24 hours. Arrangements made for physician follow-up during therapy and after its termination.

B. Hospital Discharge Planning

The following items are the responsibility of the hospital staff under the direction of the physician ordering the home IV Therapy. All activities must be completed and documented in the patient's record prior to discharge.

1. Assessment

   a. Patient's and/or primary caregiver's willingness and mental and physical capability in administering IV therapy.

   b. Patient and/or primary caregiver acceptance and understanding of the purposes, responsibilities, risks, and benefits of home IV Therapy.

   c. Mutual consent of caregiver and/or patient and physician. Consent form for home IV Therapy signed by responsible person prior to discharge with signed copy of form to home health agency. For non-hospitalized patient, consent form signed in the home by patient or other legally responsible person prior to institution of IV Therapy. A sample of a consent form has been included. (Appendix I)

   d. Availability of medical supply delivery system.

   e. Physical facilities of the patient's residence should be appropriately equipped and conducive to the safe administration of intravenous therapy.

   f. Accessibility of the home to health professionals. (Consideration of travel time as opposed to actual mileage.)

   g. Availability of nursing personnel on a 24-hour basis.

   h. Age of patient. (Children under 5 years are not deemed as appropriate candidates for fluid replacment home IV Therapy, however, exceptions can be considered in specific cases. The opinions of all members of the health team, including the family must be taken into consideration before a final decision is made.)

   i. The illness or condition should be amenable to care at home including reasonable expectation that the patient's medical, nursing and social needs can be met adequately in the home including a plan to meet medical emergencies.

2. Teaching

   Teaching (includes instruction, discussion, demonstration of and return demonstration by patient and/or primary caregiver) until person taught is competent in procedures to be followed at home.

Recommendations:

-Standards for teaching should be those of the National Intravenous Therapy Association (NITA). (Appendix II)

-Nursing personnel teaching IV Therapy should have specialized IV skills.

-Teaching should be done using simplified terms at the patient's and/or caregiver's level of understanding.

a. Specifics of Teaching:

(1) aseptic technique

(2) proper adminstration of IV fluids; i.e., priming IV tubing, etc

(3) signs/symptoms of complications and their specific interventions

(a) phlebitis

(b) infiltration

(c) leakage of fluid

(d) separation of line

(e) air in line

(f) contamination

(g) fluid overload

(h) occlusion

(4) procedure for 24 hour problem reporting

(5) type, amount and rate of fluids

(6) delivery system (pump, etc.)

(7) maintenance of patent IV line

(8) appropriate storage and rotation of supplies

(9) appropriate area for IV fluid administration

(10) safe discarding of disposable equipment

(11) addition of medications if ordered (i.e. vitamins, KCl)

(12) interpretation of labels on IV fluid containers to include expiration dates

(13) assessment of IV fluid for contamination

b. Written instructions (to be sent home with patient/caregiver and to be attached to all home health agency referrals).

3. Physician Referral

a. The physician is to work in close collaboration with hospital personnel in making the necessary arrangements for discharge of the patient.

b. The physician or his representative are to contact the Home Health Agency (HHA) and establish a Home Health Plan of Treatment for the IV Therapy and nursing visit(s).

c. Notification of primary care physician if other than the physician ordering the IV therapy.

d. Specifics:

(1) I.V. fluids are to be ordered according to type, amount, rate, additives, duration, route and method of delivery.

C. Community Services

1. Responsibilities of Home Health Agency Nurse[1/]

a. Collaborate with hospital staff to assure continuity of coordinated care between hospital and home to include communication with physician medical suppliers, pharmacists and other health professionals as indicated.

b. Contact with patient/caregiver same day as discharge from hospital.

c. Assess patient's condition.

d. Assess home environment and if found to be unsuitable, contact the physician.

e. Assess, review and reinforce all items in 2a above.

[1/]Refer to Appendix III for opinion statement of the Kentucky Board of Nursing (July 1984) regarding L.P.N. practice in IV Therapy.

f. Return demonstration by responsible person of procedures taught in the hospital. (Refer to NITA standards in Appendix II.)

g. Assist in identifying additional resources (especially for relief) as needed.

h. Review plans for follow-up care and coordinate community referrals as necessary.

i. Assure consent form is signed.

j. Assure that all supplies are in the home to render IV Therapy.

k. Notify the patient/caregiver of emergency numbers; home health agency, physician, medical supplier and availability of 24-hour services.

l. Visit patient on a regular and appropriate basis when on continuous IV fluid therapy as deemed necessary by the physician and/or patient's condition.

m. Maintain regular contact with physician and other disciplines as indicated.

n. Adhere to the following standards specific to <u>nursing activities</u> for IV Therapy:

(1) Check IV fluids for contamination and expiration dates

(2) Use of povidone/iodine or other approved topical anti-microbial prep for IV site (for iodine allergies use 70% alcohol prep)

(3) Change IV site every 72 hours[2/]

(4) Apply sterile occlusive dressing to IV site

(5) Remove plastic cannulas at termination of IV Therapy with proper inspection

(6) Assure that a volume limiting device is attached to IV fluid containers for pediatric patients and others where fluid overload is a potential problem

[2/] Venous access sometimes dictates frequency of site changes. Above guideline is to be used as a norm.

o. Use of Hepain lock recommended for peripheral IV therapy.

p. Refer to NITA standards, specifically recommendations of practice listed under heading #32, Home IV Therapy Programs. (Appendix II)

III. IV ANTIBIOTIC THERAPY IN THE HOME

A. Medical Criteria

1. Documentation of infection including any available culture and sensitivity reports.

2. Infectious process that can best be treated with IV antibiotics, i.e., antibiotic not available in oral form or therapeutic objectives not achieved via oral route.

3. Initiation of IV antibiotic in hospital or other medical facility.

4. Safety of IV antibiotic for home administration.

5. Patients seen by physician in preceding 48 hours before discharge.

6. Patient in clinically stable condition; exception for terminal illness with voluntary consent of patient and/or caregiver.

7. Dependable IV route.

B. Hospital Discharge Planning

The following items are the responsibility of the hospital staff under the direction of the physician ordering the home IV Therapy. All activities must be completed and documented in the patient's record prior to discharge.

1. Assessment

   a. Patient's and/or primary caregiver's willingness and mental and physical capability in administering IV therapy.

   b. Patient's and/or primary caregiver's acceptance and understanding of the purposes, responsibilities, risks, and benefits of home IV Antibiotic Therapy.

   c. Mutual consent of caregiver and/or patient and physician. Consent form for home IV Therapy signed by patient or other legally responsible person prior to discharge with signed copy of form to home health agency. A sample of a consent form has been included. (Appendix I)

   d. Availability of medical supply delivery system.

e. Physical facilities of the patient's residence should be appropriately equipped and conducive to the safe administration of intravenous therapy.

f. Accessibility of the home to health professionals. (Consideration of travel time as opposed to actual mileage.)

g. Availability of nursing personnel on a 24-hour basis.

h. The illness or condition should be amenable to care at home including reasonable expectation that the patient's medical, nursing and social needs can be met adequately in the home including a plan to meet medical emergencies.

2. Teaching

Teaching (includes instruction, discussion, demonstration of IV techniques and return demonstration by patient and/or primary caregiver) until person taught is competent in procedures to be followed at home.

Recommendations:

-Standards for teaching should be those of the National Intravenous Therapy Association (NITA). (Appendix II)

-Nursing personnel teaching IV Antibiotic Therapy should have specialized IV skills. Nurse to be knowledgeable about the specific IV antibiotic ordered (may refer to pharmacist, manufacturer's instructions, etc.).

-Teaching should be done using simplified terms at the patient and/or caregivers level of understanding.

a. Specifics of Teaching:

(1) aseptic technique

(2) proper administration of IV antibiotics

(a) appropriate "thaw time" for premixed refrigerated or frozen antibiotics
(b) antibiotics should not be given IV push. (Refers to rate)

(3) signs/symptoms of complications and their specific interventions

(a) phlebitis
(b) cellutitis
(c) infiltration

(d) break and leaks in administration set or catheters
(e) separation of line
(f) air in line
(g) air embolism
(h) contamination
(i) bleeding
(j) allergic reaction
(k) occlusion

(4) procedure for 24 hour problem reporting

(5) type, amount and rate of IV antibiotics (rate of administration important, especially with aminoglycosides)

(6) delivery system (volutrol if indicated, etc.)

(7) maintenance of patent IV line

(8) checking of bag for pin hole leaks

(9) appropriate storage and rotation of supplies (refrigeration or freezing will be necessary for premixed antibiotics)

(10) appropriate area for IV fluids administration

(11) safe discarding of disposable equipment

(12) interpretation of labels on IV antibiotics to include expiration dates

(13) assessment of IV fluid for contamination

(14) preparation of IV antibiotic if not delivered premixed

(15) appropriate intervals for administration of IV antibiotics if more than one is ordered

(16) side effects for specific antibiotic or class of antibiotics; i.e., aminoglycosides (ototoxicity;

b. Written instructions (to be sent home with patient/caregiver and to be attached to all home health agency referrals).

3. Physician Responsibilities

a. The physician is to work in close collaboration with the pharmacist and hospital personnel in making the necessary arrangements for discharge of the patient.

b. The physician or his representative is to contact the Home Health Agency (HHA) and establish a Home Health Plan of Treatment for antibiotic IV Therapy and nursing visit(s).

c. Notification of primary care physician if other than the physician ordering the IV therapy.

d. Specifics:

(1) I.V. antibiotics are to be ordered according to type, amount, rate, additives, duration, route and method of delivery

(2) Appropriate laboratory studies for:

(a) toxicity (i.e., weekly BUN, creatinine, urinalysis; hearing and vestibular testing on a regular basis for aminoglycoside therapy)

(b) therapeutic efficacy (peak and trough serum levels)

(3) Arrangements made for prompt notification of physician regarding lab values

(4) Periodic personal followup/clinical assessment by physician

4. Pharmacist Responsibilities

a. Communicate with the physician, hospital personnel and HHA to coordinate resources necessary for discharge.

b. Verify/evaluate physician's orders.

c. Evaluate for reimbursement sources.

d. Assist nurse and/or patient in teaching process as needed.

e. Assure proper preparation of IV antibiotics.

f. Prepare appropriate labels for parenteral container to include:

(1) patient's name

(2) physician's name

(3) date

(4) drug(s)

(5) dosages (strength)

(6) expiration date

(7) diluent

(8) administation rate

(9) require a Federal labeling

(10) other precautionary statement(s) if indicated

g. Act as resource person for HHA nurse in regards to antibiotic ordered.

(1) storage of antibiotic

(2) stability

(3) compatibility

(4) reconstitution of antibiotic if not premixed

(5) rate

(6) necessary supplies

(7) other information specific to antibiotic ordered

D. Community Services

1. Responsibilities of Home Health Agency Nurse[1/]

a. Collaborate with hospital staff to assure continuity of coordinated care between hospital and home to include communication with physician, medical supplier pharmacist and other health professionals as indicated.

b. Contact with patient/caregiver same day as discharge from hospital.

c. Assess patient's condition.

d. Assess home environment and if found to be unsuitable, contact the physician.

e. Assess, review and reinforce all items under Hospital Discharge Planning #2 (Teaching).

[1/] Refer to Appendix III for opinion statement of the Kentucky Board of Nursing (July 1984) regarding L.P.N. practice in IV Therapy.

f. Return demonstration by responsible person of procedures taught in the hospital. (Refer to NITA standards in Appendix II.)

g. Assist in identifying additional resources (especially for relief) as needed.

h. Review plans for follow-up care and coordinate community referrals as necessary.

i. Assure consent form is signed.

j. Assure that all supplies are in the home to render IV Therapy.

k. Notify the patient/caregiver of emergency numbers; home health agency, physician, medical supplier, and availability of 24-hour services.

l. Visit patient on a regular and appropriate basis when on antibiotic therapy as deemed necessary by the physician and/or patient's condition.

m. Assess for appropriate laboratory monitoring.

n. Maintain regular contact with physician and other disciplines as indicated. Physician to receive prompt notification of lab results.

o. Adhere to the following standards specific to <u>nursing activities</u> for Antibiotic IV Therapy:

(1) Check IV antibiotic containers for contamination and proper labeling

(2) Use of povidone/iodine or other approved topical anti-microbial prep for IV site prep (for iodine allergies use 70% alcohol prep)

(3) Use Heparin lock

(4) Change IV site every 72 hours[2/]

(5) Apply sterile occlusive dressing to IV site

(6) Remove plastic cannulas at termination of IV Therapy with proper inspection

p. Refer to NITA standards, specifically recommendations of practice listed under heading #32, Home IV Therapy Programs. (Appendix II)

[2/] Venous access sometimes dictates frequency of site changes. Above guideline is to be used as a norm.

IV. TOTAL PARENTERAL NUTRITION (TPN) IN THE HOME

A. Medical Criteria

1. Inability of patient to take nourishment by any other route.
2. Medical condition warrants ongoing need for TPN according to physician's assessment.
3. Initiation of TPN in hospital or other medical facility.
4. TPN formula has been consistent for a 3 to 4 day period.
5. Patient stabilized on TPN regimen which will be given in the home (continuous or cyclic).
6. Monitoring of lab values on regular basis (at least weekly) with stabilization of values prior to discharge.
7. Patients seen by physician in preceding 24 hours before discharge.
8. Patient in clinically stable condition; exception for terminal illness with voluntary consent of patient and/or caregiver.
9. Intact central line.

B. Hospital Discharge Planning

The following items are the responsibility of the hospital staff under the direction of the physician ordering the home TPN Therapy. All activities must be completed and documented in the patient's record prior to discharge.

1. Assessment

   a. Patient's and/or primary caregiver's willingness and mental and physical capability in administering TPN therapy.

   b. Patient's and/or primary caregiver's acceptance and understanding of the purposes, responsibilities, risks, and benefits of home TPN Therapy.

   c. Mutual consent of caregiver and/or patient and physician. Consent form for home TPN Therapy signed by patient or other legally responsible person prior to discharge with signed copy of form to home health agency. A sample of a consent form has been included. (Appendix I)

d. Availability of medical supply delivery system.

e. Physical facilities of the patient's residence should be appropriately equipped and conducive to the safe administration of TPN therapy.

f. Accessibility of the home to health professionals. (Consideration of travel time as opposed to actual mileage.)

g. Availability of nursing and pharmacy personnel on a 24-hour basis.

h. The illness or condition should be amenable to care at home including reasonable expectation that the patient's medical, nursing and social needs can be met adequately in the home including a plan to meet medical emergencies.

2. Teaching

Teaching (includes instruction, discussion, demonstration of TPN techniques and return demonstration by patient and/or primary caregiver) until person taught is competent in procedures to be followed at home.

Recommendations:

-Standards for teaching should be those of the National Intravenous Therapy Association (NITA). (Appendix II)

-Nursing personnel teaching TPN Therapy should have specialized IV skills and be knowledgeable in the specifics of TPN Therapy (may refer to pharmacist, manufacturer's instructions, etc.).

-Teaching should be done using simplified terms at the patient and/or caregivers level of understanding.

a. Specifics of Teaching:

(1) aseptic technique

(2) proper administration of TPN

(a) infusion controller device necessary (recommend simplified pump with alarm system)

(b) warming of refrigerated TPN solution for approximately 18 - 24 hours at room temperature

(c) use of filter (.22 micron) - lipid solutions to be infused below filter as close to catheter as possible
(d) ordered additives (vitamins, etc.) to be added to TPN solution just prior to administration

(3) signs/symptoms of complications and their specific interventions

(a) hypo/hyperglycemia
(b) fluid overload
(c) dehydration
(d) local and systemic infections
(e) electrolyte imbalances
(f) breaks and leaks in administration set, catheter line, solution container
(g) thrombophlebitis
(h) air embolism
(i) bleeding
(j) fatty embolism
(k) occlusion
(l) separation of line
(m) infiltration
(n) pump problems

(4) procedure for 24 hour problem reporting

(a) physician
(b) HHA nurse
(c) supply company (vendor)
(d) ambulance
(e) pharmacist

(5) notification of utility companies

(6) list of composition of TPN solution to include amount and rate

(7) cyclic or continuous administration

(a) tapering schedule for cyclic administration as ordered

(8) maintenance of patent central line-heparinization

(9) use of approved central catheter clamps

(a) proper clamping
(b) weekly rotation of clamp site

(10) assessment of TPN containers for leaks, contamination and proper labeling

(11) appropriate storage and rotation of supplies

(12) recorded inventory checks on regular basis

(13) appropriate refrigeration of TPN solutions

(14) appropriate work area for preparation, initiation and discontinuation of TPN

(15) safe discard of disposables

(16) monitoring of urine sugar/acetone on a regular basis during and after TPN administration

(17) daily monitoring of temperature

(18) daily weights if practical

(19) intake and output if ordered by physician

(20) ongoing assessment for complications with notification of physician, HHA nurse if they occur

(21) care of central catheter site (clean/sterile) (with Hickman/Broviac Catheters, use sterile technique first month, then may use clean technique)

(a) use of povidone/iodine prep at catheter site
(b) sterile occlusive dressing to be changed on a regular basis and prn
(c) percutaneous catheter-must use sterile technique

(22) securing all catheter junctions and taping of catheter to body

(23) daily changing of luer-lock catheter caps using sterile technique

(a) for multiple lumen catheter, change cap of active lumen
(b) use of Valsalva maneuver when changing caps of percutaneous line

(24) TPN line should not to be used for other medical purposes (except where there are no other alternatives, terminal patients - no other venous access)

(25) changing of administration set every 24 hours

(26) TPN solution to hang no more than 24 hours

(27) lipid solution to hang no more than 12 hours

(28) oral hygiene bid

(29) promotion of active physical exercise in accordance with patient's capabilities

b. Written instructions (to be sent home with patient/caregiver and to be attached to all home health agency referrals).

3. Physician Responsibilities

a. The physician is to work in close collaboration with the pharmacist and hospital personnel in making the necessary arrangements for discharge of the patient.

b. The physician or his representative is to contact the Home Health Agency (HHA) and establish a Home Health Plan of Treatment for TPN Therapy and nursing visit(s).

c. Notification of primary care physician if other than the physician ordering the IV therapy.

d. Specifics:

(1) TPN therapy is to be ordered according to concentration of glucose/amino acid mixture, amount, rate, additives, duration, route and method of delivery

(2) Appropriate laboratory studies should include:

(a) SMA-18 or equivalent battery of tests, mg^{++} level 1 - 2 times per month after patient is stablized

(3) Arrangements made for prompt notification of physician regarding lab values

(4) Periodic personal followup/clinical assessment by physician

(5) Determination as to discontinuation of TPN (specify tapering schedule)

4. Pharmacist Responsibilities

a. Communicate with the physician, hospital personnel and HHA to coordinate resources necessary for discharge.

b. Verify/evaluate physician's orders.

(1) Advise/counsel physician regarding availability and selection of TPN products

c. Evaluate for reimbursement sources.

d. Assist nurse and/or patient in teaching process as needed.

e. Assure proper preparation of TPN solution.

(1) sterile technique required
(2) follow manufacturer instructions for preparation
(3) prepared by pharmacist or trained technician under direct supervision of pharmacist

f. Prepare labels for TPN container to include:

(1) patient's name
(2) date
(3) physician
(4) concentration of glucose/amino acid mixture
(5) additives
(6) dosages
(7) expiration date
(8) required Federal labeling
(9) other precautionary statements if indicated

g. Act as resource person for HHA nurse in regards to TPN solutions.

(1) storage of TPN
(2) stability
(3) compatibility
(4) preparation of TPN in home if not premixed
(5) rate
(6) necessary supplies
(7) administration
(8) complications
(9) other information specific to TPN

D. Community Services

1. Responsibilities of Home Health Agency Nurse[1/]

a. Collaborate with hospital staff to assure continuity of coordinated care between hospital and home to include communication with physician, medical suppliers, pharmacist and other health professionals as indicated.

[1/] Refer to Appendix III for opinion statement of the Kentucky Board of Nursing (July 1984) regarding L.P.N. practice in IV Therapy.

b. Contact with patient/caregiver same day as discharge from hospital.

c. Assess patient's condition.

d. Assess home environment and if found to be unsuitable, contact the physician.

e. Assess, review and reinforce all items under Hospital Discharge Planning #2 (Teaching).

f. Return demonstration by responsible person of procedures taught in the hospital.

g. Assist in identifying additional resources (especially for relief) as needed.

h. Review plans for follow-up care and coordinate community referrals as necessary.

i. Assure consent form is signed.

j. Assure that all supplies are in the home to render TPN Therapy.

k. Notify the patient/caregiver of emergency numbers; home health agency, physician, medical supplier, and availability of 24-hour services.

l. Visit patient on a regular and appropriate basis when on TPN therapy as deemed necessary by the physician and/or patient's condition.

m. Assess for appropriate laboratory monitoring.

n. Maintain regular contact with physician and other disciplines as indicated. Physician to receive prompt notification of lab results.

o. Addition of extension set to percutaneous catheter if indicated.

Refer to NITA standards, specifically recommendations of practice listed under heading #32, Home IV Therapy Programs. (Appendix II)

E. Special Considerations

1. Self-Mixing of TPN Solutions in the Home.

a. Careful assessment of patient's or primary caregiver's willingness and physical and mental capability in self-mixing and administering TPN.

b. Appropriate well-ventilated work area identified specifically for self-mixing.

c. Proper procedures for preparing work area just prior to self-mixing.

d. Sterile gloves to be worn during preparation (mask to be work if deemed necessary - upper respiratory infection).

e. Sterile technique.

f. Demonstration at home by person preparing TPN.

g. Written instructions of step-by-step procedure for self-mixing.

h. Preparation to be done just prior to administration; therefore, refrigeration not required.

i. Agitation of TPN container after each additive.

j. Addition of additives in proper sequence (see manufacturer's instructions).

k. Follow other guidelines specified for pre-mixed TPN solutions.

2. Implantable Venous Access Devices (IVAD's) in TPN Therapy.

a. Use of #19G Huber needle (right angle) with extension set. Needle to be changed weekly and prn.

b. Heparinization of IVAD with at least 9 cc Heparin (due to extension set).

c. Weekly dressing change to coincide with needle change (use transparent sterile dressing).

d. Keep record of number of punctures and gauge needle used.

e. Discourage use of ILAD for obtaining blood specimens.

f. Person with IVAD should carry ID regarding IVAD and its location.

g. Follow other guidelines for TPN specified in this protocol.

V. IV CANCER CHEMOTHERAPY IN THE HOME

Introduction

The following protocol reflects current, accepted practice in the administration of IV chemotherapy. Much research is being done in the field of IV chemotherapy which will result in new methods of treatment. Therefore, the guidelines contained herein are stated in general terms. Professional health personnel involved with home IV chemotherapy need to be aware of the rapid changes occurring in this type of therapy which will require that they contact knowledgeable medical personnel to obtain up-to-date information and guidance in the proper procedures necessary for safe administration of IV cancer chemotherapy in the home.

A. Medical Criteria

1. Initial doses of IV chemotherapy given in medical facility (hospital, outpatient clinic or other location where physician in attendance).

2. IV chemotherapy can be safely administered in the home.

3. Patient has difficulty accessing medical facility and desires chemotherapy in the home.

4. Acceptable lab values (blood counts and chemistries as indicated) with periodic evaluations.

5. Assessment of patient's physical and mental status by physician to determine candidacy for home IV chemotherapy.

6. Approved and seen by physician in preceding 24-48 hours with arrangements made.

7. Provision made for local physician to follow if patient has more than 2 hour drive to location where chemotherapy was instituted. Arrangements should include written correspondence, discharge summaries and lab and x-ray reports as a minimum.

8. Hospital Discharge Planning

The following items are the responsibility of the hospital staff under the direction of the physician ordering the home IV chemotherapy. All activities must be completed and documented in the patient's record prior to discharge.

1. Assessment

a. Patient's and/or primary caregiver's willingness and mental and physical capability in administering IV chemotherapy.

b. Patient's and/or primary caregiver's acceptance and understanding of the purposes, responsibilities, risks, and benefits of home IV chemotherapy.

c. Mutual consent of caregiver and/or patient and physician. Consent form for home IV chemotherapy signed by patient or other legally responsible person prior to discharge with signed copy of form to home health agency. A sample of a consent form has been included. (Appendix I)

d. Availability of medical supply delivery system.

e. Physical facilities of the patient's residence should be appropriately equipped and conducive to the safe administration of IV chemotherapy.

f. Accessibility of the home to health professionals. (Consideration of travel time as opposed to actual mileage.)

g. Availability of nursing and pharmacy personnel on a 24-hour basis.

h. The illness or condition should be amenable to care at home including reasonable expectation that the patient's medical, nursing and social needs can be met adequately in the home including a plan to meet medical emergencies.

2. Teaching

Teaching (includes instruction, discussion, demonstration of IV chemotherapy techniques and return demonstration by patient and/or primary caregiver) until person taught is competent in procedures to be followed at home.

Recommendations:

-Standards of teaching should be those of the National Intravenous Therapy Association (NITA). (Appendix II)

-Nursing personnel teaching IV chemotherapy should have specialized IV skills and be knowledgeable in the specifics of IV chemotherapy (may refer to pharmacist, manufacturer's instructions, etc.).

-Teaching should be done using simplified terms at the patient and/or caregivers level of understanding.

a. Specifics of Teaching:

(1) aseptic technique

(2) proper administration of IV chemotherapy

(a) refrigeration of chemotherapy solutions in a separate compartment in refrigerator (sealed in plastic container)
(b) warming of chemotherapy solution according to pharmacists' instructions
(c) use of .22 micron filter (Exception: No filter with actinomycin-D)
(d) use of appropriate infusion device (small volume with alarm)

(3) complications

(a) drug-related (depends on type chemotherapy agent being administered)

(1) oral lesions
(2) G-I disturbances
(3) alopecia
(4) neurological disturbances
(5) anemia
(6) hematological side effects
(7) electrolyte imbalances
(8) cardiac toxicity
(9) pulmonary toxicity
(10) vascular disturbances
(11) flu-like syndrome (malaise)
(12) genitourinary disturbances
(13) anaphylaxis
aa. specify procedures for treating/transporting

(b) prompt notification of physician when complications/side effects occur

(c) other complications

(1) sepsis
(2) breaks and leaks in administration set, catheter line, solution container
(3) thrombophlebitis
(4) air embolism
(5) bleeding
(6) occlusion
(7) separation of line
(8) extravasation
aa. specify procedures to use for extravasation
(9) pump problems

(4) procedure for 24 hour problem reporting

(a) physician
(b) HHA nurse
(c) supply company (vendor)
(d) ambulance
(e) pharmacist

(5) notification of utility companies

(6) list of composition of chemotherapy solution to include amount, rate and expiration date

(7) short or long term administration (depends on drug ordered)

(8) maintenance of patent central line-heparinization

(9) use of approved central catheter clamps

(a) proper clamping
(b) weekly rotation of clamp site

(10) assessment of chemotherapy containers for leaks, contamination and proper labeling (do not squeeze bag)

(11) appropriate storage and rotation of supplies

(12) recorded inventory checks on regular basis

(13) appropriate work area for initiation and discontinuation of chemotherapy solution

Note: Strongly recommend that chemotherapy solutions not be mixed in the home.

(14) disposable gown, latex gloves and mask to be worn during initiation and discontinuation of chemotherapy solution - use double gloves for cleaning spills

(15) discard all disposables in contact with chemotherapy solution in leak and puncture proof containers marked hazardous wastes and place in sealed container - transport to medical facility for disposal

(16) procedure to be used if accidents occur - accidential needlestick, spills

(17) daily monitoring of temperature

(18) daily weights if practical

(19) ongoing assessment for complications with notification of physician, HHA nurse if they occur

(20) care of central catheter if patient has one (clean/sterile-with Hickman/Broviac Catheters, use sterile technique first month, then may use clean technique)

(a) use of povidone/iodine prep at catheter site
(b) sterile occlusive dressing to be changed on a regular basis and prn
(c) percutaneous catheter-must use sterile technique

(21) securing all catheter junctions and taping of catheter to body

(22) changing of luer-lock catheter caps using sterile technique after each dose chemotherapy; twice per week when not receiving chemotherapy

(a) for multiple lumen catheter, change cap of active lumen
(b) use of Valsalva maneuver when changing caps of percutaneous line

(23) chemotherapy line should not be used for other medical purposes (except where there are no other alternatives, terminal patients - no other venous access)

Note: Strongly recommend that home IV chemotherapy be administered via central line, especially vesicants.

(24) change IV tubing with each dose of chemotherapy (for a 3-5 day continuous infusion, do not change tubing). All tubing to be primed with chemotherapy solution prior to infusion

(25) chemotherapy solution to hang for as long as ordered

(26) all connecting sites on IV apparatus are to have luer-lock devices and be taped

(27) oral hygiene bid

(28) promotion of active physical exercise in accordance with patient's capabilities

b. Written instructions to be sent home with patient/caregiver and to be attached to all home health agency referrals.

3. Physician Responsibilities

a. The physician is to work in close collaboration with the pharmacist and hospital personnel in making the necessary arrangements for discharge of the patient.

b. The physician or his representative is to contact the Home Health Agency (HHA) and establish a Home Health Plan of Treatment for chemotherapy and nursing visit(s).

c. Notification of primary care physician if other than the physician ordering the chemotherapy.

d. Specifics:

(1) chemotherapy orders to include:

(a) name of drug
(b) dose
(c) rate
(d) duration
(e) route
(f) method of delivery

(2) periodic lab studies required and ordered according to drug being given

(3) periodic accessments of patient by physician and/or representative

(4) automatic stop orders for IV chemotherapy for particular lab values and/or physical findings

4. Pharmacist Responsibilities

Introduction

Pharmacists involved in the preparation of IV chemotherapy agents should possess adequate knowledge and skills related to the specific requirements of ordering, storing, preparing, handling and disposing of chemotherapy drugs and supplies. They should also be knowledgeable regarding proper dilutions, administration guidelines and special precautions. It is recommended that these pharmacists possess up-to-date reference materials and develop good working relationships with personnel who are experts in the field of chemotherapy.

a. Communicate with the physician, hospital personnel and HHA to coordinate resources necessary for discharge.

b. Verify/evaluate physician's orders according to compatibility with other drugs/fluids, dose levels, administration rates.

c. Evaluate for reimbursement sources.

d. Assist nurse and/or patient in teaching process.

e. Assure proper preparation of chemotherapy solution.

Note: Recommend that Type II, Class 83 vertical flow hood be used for preparation.

(1) sterile technique required
(2) follow manufacturer's instructions for preparation
(3) prepared by pharmacist or trained technician under direct supervision of pharmacist using proper attire as indicated

f. Prepare labels for chemotherapy container to include:

(1) patient's name
(2) date
(3) physician
(4) concentration of chemotherapy agent
(5) dosages
(6) expiration date
(7) required Federal labeling
(8) other precautionary statements

g. Act as resource person for HHA nurse in regards to chemotherapy agents.

(1) storage
(2) stability
(3) compatibility
(4) rate
(5) necessary supplies
(6) administration
(7) complications
(8) other information specific to chemotherapy agent being used
(9) proper disposal of supplies used in administration of chemotherapy

h. Maintain patient profile including cumulative doses of chemotherapy agent.

D. Community Services

1. Responsibilities of Home Health Agency Nurse[1/]

a. Collaborate with hospital staff to assure continuity of coordinated care between hospital and home to include communication with physician, medical suppliers, pharmacist and other health professionals as indicated.

b. Contact with patient/caregiver same day as discharge from hospital.

c. Assess patient's condition.

d. Assess home environment prior to patient discharge and, if found to be unsuitable, contact the physician.

e. Assess, review and reinforce all items under Hospital Discharge Planning #2 (Teaching).

f. Return demonstration by responsible person of procedures taught in the hospital.

g. Assist in identifying additional resources (especially for relief) as needed.

h. Review plans for follow-up care and coordinate community referrals as necessary.

i. Assure consent form is signed.

j. Assure that all supplies are in the home to render chemotherapy.

k. Notify the patient/caregiver of emergency numbers; home health agency, physician, medical supplier, and availability of 24-hour services.

l. Visit patient on a regular and appropriate basis when on chemotherapy as deemed necessary by the physician and/or patient's condition.

m. Assure periodic laboratory monitoring specific to the chemotherapy being ordered.

n. Maintain regular contact with physician and other disciplines as indicated. Physician to receive prompt notification of lab results and physical assessment findings.

[1/] Refer to Appendix III for opinion statement of the Kentucky Board of Nursing (July 1984) regarding L.P.N. practice in IV Therapy.

o. Strict adherence to proper disposal of chemotherapy supplies.

p. Maintain close contact with pharmacist regarding chemotherapy agent being used.

q. If patient on 3-5 day concentrated infusion, at termination of infusion, withdraw remaining chemotherapy agent out of central line (volume will depend on type of central catheter), flush with saline and heparinize.

r. Carefully assess for extravasation if IVAD (implantable venous access device) is being used.

Refer to NITA standards, specifically recommendations of practice listed under heading #32, Home IV Therapy Programs. (Appendix II)

APPENDIX I

Patient's Consent For Non-Nurse Administered
Intravenous Therapy In The Home

I, _____ consent to
(Patient's Full Name)

_____, who is my _____ having
(Full Name) (Relationship)

responsibility for administering intravenous medications/fluids prescribed by my physician and needed by me at my home.

I understand that _____ will be administering
(Full Name)

and monitoring the intravenous therapy in the absence of the visiting nurse.

I understand that _____ has received instruction,
(Full Name)

but that the instruction is not as complete as the training of the nurse.

I understand that only specially trained nurses will be assigned to provide home care to me and that precautions will be taken to avoid complications. However, I realize that at times complications occur despite meticulous attention.

I understand that a visiting nurse service is an intermittent service and the nurse may not be present at the time of the therapy or when complications/emergencies could arise.

I agree to release _____
(Name of Home Health Agency)

and any of its agents, servants or employees from any and all claims or causes of action which I, or any of my heirs, successors, or assigns may have arising out of the administering of my intravenous therapy whether or not it is related to the instruction which _____
(Full Name)

received or any other reason.

I have the right to discontinue home intravenous therapy upon notification of my doctor.

My signature certifies that I have read and understand and consent to the administration of intravenous therapy in the home.

_____ Signed: _____
(Date) (Patient)

_____ Or: _____
(Witness) (Responsible Adult)

_____
(Relationship to Patient)

all practices. Knowledge and understanding of all possible complications associated with I.V. therapy and the ability to recognize the occurance of such reactions, make clinical judgements and initiate proper nursing intervention.

l. Blood Component Therapy
To provide the registered professional nurse with knowledge of immunohematology, blood grouping, blood and blood components, equipment and reactions. The registered professional nurse shall be knowledgeable of the selection and protection of blood donors, the fractionation of blood into its components and the laboratory testing required for determining compatibility. Emphasis shall be placed on the administration of blood and its components and the recognition and management of any adverse reactions which the patient may experience.

m. Parenteral Nutrition
To provide the registered professional nurse with the knowledge in clinical application of parenteral nutrition including assessment, initiation, maintenance and termination of the therapy. Emphasis should be placed on metabolic processes, potential complications and preventive measures to insure the desired therapeutic effect.

n. Chemotherapy
To provide the registered professional nurse knowledge and understanding of the basic principles of cancer therapy and administration of I.V. antineoplastic agents.

2. Clinical
All clinical aspects of I.V. therapy shall be supervised until proficiency is determined acceptable by observation and approval of returned demonstrations and clinical judgement is assessed as competent.

APPENDIX II

Standards

Recommendations of Practice

1. I.V. Nursing Teams
Professional, specially trained I.V. nursing teams decrease the risk of I.V. related complications and infections, insure patient protection, deliver quality I.V. care and are cost effective.

Recommendations of Practice
1. I.V. nursing teams should be placed under one of the following hospital departments: Pharmacy, Blood Bank, Pathology, Administration, and have a close relationship with Nursing Service and the Infection Control Department.
2. I.V. Departments should be an independent department.
3. I.V. Departments should be cost effective.
4. I.V. Departments shall have a medical advisor who is a physician.
5. All I.V. policies and procedures shall be approved by a member of the medical staff.
6. All I.V. policies and procedures shall be reviewed and updated annually.

2. I.V. Policies and Procedures
To insure safe and standardized I.V. therapy within the health care facility; to protect the patient by maximizing benefits and minimizing risks associated with this therapy and to protect the practice(s) of the registered professional I.V. nurse.

Recommendations of Practice
1. I.V. policies shall be written general statements that encompass a specific area of practice.
2. I.V. procedures shall be written and specifically detailed to a particular I.V. practice.
3. I.V. policies and procedures shall be submitted by an I.V. Supervisor, by the medical staff and appropriate hospital governing body that governs the specialty of I.V. therapy.
4. I.V. policies and procedures that are established within a given institution are solely intended for use within that particular institution.
5. I.V. policies and procedures shall be updated continuously and reviewed annually.
6. All registered professional I.V. nurses are accountable for thorough knowledge of the I.V. policies and procedures within their particular institution.
7. I.V. policies and procedures should be in keeping with these Standards.

3. Initiation of I.V. Therapy
The initiation of I.V. therapy shall be to provide intravascular access for definite therapeutic or diagnostic indications.

Recommendations of Practice
1. Ascertain the physician's order.

written and signed. If a verbal order is taken from a physician by a registered professional I.V. nurse, the verbal order shall be written and signed as soon as possible.

3. The nursing process shall be utilized in evaluating the medical order and the patient's needs.
4. Identify the patient.
5. Explain the procedure, specific therapy and consideration of therapy to the patient.
6. Collect and assemble appropriate equipment so the equipment will be aseptically handled in order of its use.

4. Choice of Cannula for Peripheral Infusions

Use the smallest gauge device that will achieve the prescribed treatment and a vein large enough to maintain sufficient blood flow around the I.V. device.

1. Plastic catheters shall be used for routine peripheral I.V. therapy in order to establish a secure access to the vascular system.
2. Stainless steel cannulas may be used for short-term or one-dose peripheral I.V. therapy but tend to infiltrate and dislodge more frequently than I.V. plastic catheters.
3. This Association advocates the use of radiopaque catheters for I.V. use.
4. Stylets shall never be reinserted when I.V. catheters are initiated.
5. Through-the-needle catheters are not recommended for routine peripheral I.V. use.
6. Only one device shall be utilized for each attempt.
7. The nurse should not make more than two attempts to initiate I.V. therapy.

5. Handwashing

Before inserting an I.V. cannula, hospital personnel shall wash their hands.

Recommendations of Practice

1. Soap and water is adequate for most peripheral insertions.
2. An antiseptic solution should be used for handwashing prior to the insertion of peripheral central catheters.

6. Site Selection

In vein selection, the patient's condition, vein condition, age and the type and duration of therapy shall be assessed to insure ideal and safe I.V. access.

Recommendations of Practice

1. Veins most appropriate for I.V. therapy are metacarpal veins, cephalic veins, basilic veins and the median veins.
2. Start peripheral routine I.V. therapy in distal areas of the upper extremities.
3. Palpation of the vein is important in assessing the condition of the vein and in differentiating it from an artery. Fingers should be used for palpation to access the vein. The thumb shall not be used since it is not as sensitive as the fingers and the thumb pulse may be confused in detecting an artery.
4. To distend the vein, apply a tourniquet or pressure cuff 4-6 inches above the site selected.
5. Tourniquets should be applied with enough pressure to stop venous flow but not arterial flow.
6. Application of heat may be indicated for promotion of vein dilitation. Care should be taken to avoid burns when applying heat.
7. Subsequent venipunctures should be made in areas proximal to previous I.V. sites.
8. Avoid the antecubital fossa since this is the preferred site of venipuncture for drawing blood tests and peripheral central line access.
9. Avoid lower extremities (legs) unless specifically ordered by the physician or necessitated by the patient's condition.
10. Cannulas inserted into lower extremities shall be changed as soon as a satisfactory site can be established.
11. Avoid previously used veins, injured veins and sclerotic veins and areas of flexion unless you immobilize the joint with an armboard or similar device.
12. Avoid veins in the affected arm of an axillary dissection.

Consideration

Liquid crystal thermographic patterns may be considered in evaluating venous physiology for site selection.

7. Site Preparation

The I.V. site shall be scrubbed with an antiseptic solution prior to venipuncture insertion.

Recommendations of Practice

1. If necessary, wash the skin with soap and water prior to application of antiseptic solution.
2. When excessive hair exists, clipping the hair is recommended rather than shaving.
3. Tincture of iodine (1-2%), iodophors or 70% isopropyl alcohol can be used as antiseptic solutions.
4. If the patient is sensitive to iodine, 70% isopropyl alcohol is recommended.
5. The antiseptic solution should be applied liberally and allowed to dry.
6. In an emergency, when there has been inadequate skin preparation, as soon as the patient has been stabilized, a second line should be established, the emergency line removed and the previous site observed for 48 hours.

8. Cannula Placement

Safe and effective I.V. access is accomplished by strict aseptic cannula placement.

Recommendations of Practice

1. Prior to use, the nurse shall confirm the integrity of the product.
2. Product defects should be ascertained by inspection and if defective, the product should be discarded and returned to the manufacturer.

sites for peripheral vascular access.

4. Strict aseptic technique shall be adhered to for cannula placement. In an emergency situation, when an I.V. cannula has been placed without adequate skin preparation, the I.V. cannula should be removed as soon as possible and the previous site observed for 48 hours.
5. Irrigation of I.V. cannulas should be avoided.
6. The type, gauge, length, insertion date and initials of person inserting the device shall be recorded in the medical record and written on a tape, close to the dressing, where it can be easily identified.
7. The cannula should be secured to stabilize it at the insertion site.
8. The nurse shall ascertain patency and placement of the cannula after placement. Evaluation of patency and placement should continue throughout therapy.

Consideration

Maximum mobility and easy viewing should be taken into consideration when taping and securing an I.V. cannula.

9. **Cannula Site and I.V. Dressing Care**

Cannula site and I.V. dressing care is to provide regular, standardized cannula site inspection, site care and to apply a sterile dressing. These measures should reduce or prevent the complications of cannula related sepsis.

Recommendations of Practice

1. If a topical ointment is used, it should be applied at the I.V. site at the time of insertion.
2. If a topical ointment is used, the use of antimicrobial (povidone-iodine) is the ointment of choice and widely accepted.
3. A sterile dressing shall be applied over all I.V. sites to cover the I.V. cannula entrance site.
4. A sterile transparent, semi-permeable membrane adhesive dressing may be applied over I.V. sites to cover the I.V. cannula entrance site.

Consideration

Some researchers have suggested that the use of polyantibiotic ointment may be efficacious at the skin-cannula junction site and that antiseptic ointments, e.g., povidone-iodine have marginal benefits.

10. **I.V. Cannula Removal**

Peripheral I.V. cannulas shall be routinely changed every 48-72 hours. Peripheral I.V. cannulas shall be inspected and evaluated through an intact dressing at least every 8 hours. These measures should reduce or prevent cannula related complications.

Recommendations of Practice

1. Routine peripheral I.V. cannulas shall be changed to a new site every 48-72 hours provided no I.V. related complications are encountered before this time.
2. Cannulas inserted in an emergency situation new site at the earliest opportunity.
3. Peripheral cannulas that must remain in place for prolonged periods (over 72 hours) due to the patient's condition should be considered a higher risk of potential complication and require more frequent assessment and evaluation.
4. The cannula should be removed if there is pain or tenderness at the insertion site.
5. Intermittent devices (heparin locks) shall be treated as peripheral cannulas.
6. Central catheters that are inserted through a peripheral vein and peripheral arterial catheter should be treated as a peripheral catheter. The proper frequency for changing these catheters is not known.
7. The nurse, as dictated by hospital policy, will remove central venous catheters, using aseptic, no-touch technique.
8. To ascertain complete removal of the catheter, the nurse will assess the length of the terminated catheter and inspect visually the tip for smoothness.

Considerations

1. The nurse, as dictated by established hospital policy, will culture appropriately the catheter in a routine, standardized manner, using aseptic, no touch technique. This practice should be especially encouraged when the catheter is suspected of being contaminated or when the patient has an unexplained fever.
2. A semiquantitative method of catheter culture is recommended.

11. **I.V. Administration Set Change**

Changing the I.V. administration set is to prevent or minimize sepsis related to the I.V. delivery system.

Recommendations of Practice

1. I.V. administration tubing shall be changed every 24-48 hours.
2. Changing of I.V. administration sets should be carried out in a routine, standardized manner and at the time a new container of I.V. solution is initiated.
3. An appropriate method of indicating the date of change of administration shall be employed.
4. "Piggy-back" tubing shall be routinely changed every 24 hours.
5. "Piggy-back" administration sets accommodating blood, blood products or lipid emulsions should be changed immediately after their administration.
6. I.V. administration sets used for Total Parenteral Nutrition should be changed every 24 hours.
7. Tubing junctions should be secured by an appropriate method such as can be accomplished with a luer lock or junction clasping device.
8. All additives to the administration set such as stop-cocks and extension tubings should be changed at the same time the I.V. administration set is changed.

9. I.V. systems should be maintained as closed systems whenever possible. All entries into the administration set such as the administration of medications should be made through injection ports that are disinfected before entry.
10. Blood specimens should not be withdrawn through I.V. tubing.
11. Flushing or irrigation of the I.V. system to improve flow should be avoided.
12. The entire I.V. system (cannula, administration set and fluid) shall be changed immediately if purulent thrombophlebitis, cellulitis or I.V. related bacteremia are noted or strongly suspected.
13. For phlebitis, without concomitant signs of infection, the cannula and administration set should be changed and the fluid evaluated as a possible source for phlebitis.

12. Dressing Changes

Changing I.V. dressings is to evaluate the insertion site, prevent complications and minimize sepsis.

Recommendations of Practice

1. The I.V. dressing should be changed every 24-48 hours and immediately if the dressing becomes soiled, wet or loose.
2. Aseptic technique shall be used to change I.V. dressings.
3. During dressing change, the insertion site should be inspected and evaluated for redness, swelling and other signs and symptoms of infection.
4. If the dressing is changed, the site should be cleaned with 70% isopropyl alcohol or povidone-iodine solution and allowed to dry, followed by reapplication of iodophor ointment and sterile dressing.

13. Culturing for Suspected I.V. Related Infections

Culturing is to ascertain the source and microorganisms of suspected contamination.

Recommendations of Practice

1. If the I.V. system is terminated because of suspected I.V. related infection, i.e., purulent thrombophlebitis and bacteremia, the skin at the cannula junction should be cleaned with alcohol and allowed to dry before the cannula is removed. The cannula should be cultured using a semiquantitative technique.
2. If the I.V. system is terminated because of suspected fluid contamination or related bacteremia, the fluid should be cultured and the implicated bottle saved and the lot number recorded.
3. If intrinsic contamination (contamination during manufacturing) is suspected, the health authorities should be notified immediately.

14. Quality Control of I.V. Solutions

To observe for possible intrinsic contamination and assure against possible extrinsic contamination complications.

Recommendations of Practice

1. Personnel shall wash their hands before opening and administering parenteral fluids.
2. All containers of parenteral fluid shall be inspected prior to use and checked for visible turbidity, discoloration, leaks, cracks, damaged caps, particulate matter and for the manufacturers expiration date before use. If a problem is found, the fluid shall not be used.
3. Once started, all parenteral fluids shall be completely used or discarded within 24 hours.
4. Infusions of lipid emulsions should be completed within 12 hours of starting.
5. All parenteral solutions shall have affixed a label indicating time and date started.

15. Admixture of Parenteral Fluids

To insure control and minimize possible complications of parenteral compounding.

Recommendations of Practice

1. Parenteral and hyperalimentation fluids should be admixed in the pharmacy unless clinical urgency requires admixture in patient-care areas.
2. Personnel shall wash their hands before admixing.
3. Single dose vials should be used for admixture whenever possible.
4. All medications should be compounded using the manufacturers recommendations.
5. A distinctive supplementary label shall be affixed to all admixed (compounded) parenteral solutions stating the additive, dosage, solution, amount, date, time of compounding, expiration date and person who did the compounding.
6. A laminar flow hood should be used for admixing parenteral solutions.
7. Handling of admixtures should be in keeping with the Recommendations Guidelines and Standards of the American Society of Hospital Pharmacists.
8. Compatibility of solution ingredients shall be authorized by the pharmacy before admixing.
9. In the absence of a vacuum, an I.V. solution container shall be covered with a sterile air tight, water proof cover after admixture.
10. When admixing occurs outside the pharmacy, hospital policy shall be strictly observed and absolute aseptic technique practiced.

16. Intermittent I.V. Therapy

A mechanism for intermittent I.V. therapy shall be employed to provide intravascular access for the patient whose condition will possibly require or necessitate definite therapeutic or diagnostic I.V. therapy. Intermittent I.V. therapy shall be employed when continuous therapy is not required by the patient's condition.

Recommendations of Practice

1. Intermittent vascular access shall be treated as I.V. peripheral catheters.

7. All I.V. cannulas locked with a rubber port male adapter may be used for intermittent I.V. therapy.
3. If heparin is used, a dose of heparin that does not alter the patient's clotting factors shall be used for maintaining patency of I.V. intermittent cannula devices. These devices should be flushed with heparinized saline solution routinely and whenever necessary to maintain patency.
4. The use of obturators is not recommended.
5. In flushing intermittent devices, consideration should be given to drug incompatibilities.
6. Use of small bore and short length needles is recommended for administering I.V. therapy through rubber ports of the intermittent device.
7. The optimal frequency for entering the rubber port is not known and leakage depends on the size of the needle inserted through the rubber port and the specific grade of rubber.
8. Utilization of intermittent devices may be established by hospital policy and may be useful in the maintenance of intermittent medications, blood and blood components, I.V. fluids, or as vascular access for the critically ill patient or unstabilized patient, for laboratory procedures and for home I.V. therapy.

17. **Labeling of I.V. Administration Sets, Cannulas and I.V. Solutions**
1. All I.V. solutions shall be labeled according to the Standards of Practice as stated in the section *Quality Control of I.V. Solutions* under the Recommendations of Practice.
2. All admixed parenteral fluids shall be labeled according to the Standards of Practice as stated in the section *Admixture of Parenteral Fluids* under the Recommendations of Practice.
3. All I.V. administration sets shall be labeled according to the Standards of Practice as stated in the section *I.V. Administration Set Change* under the Recommendations of Practice.
4. All I.V. cannulas shall be labeled according to the Standards of Practice as stated in the section *Cannula Placement* under the Recommendations of Practice.

18. **Administration of I.V. Medications**
Administration of I.V. medications shall be initiated by a prescription of a medical doctor and provide a therapeutic outcome.

Recommendations of Practice
1. The registered professional I.V. nurse may administer I.V. medications which have been established by hospital policy and in accordance with individual state regulations.
2. The health care facility shall provide a list of approved I.V. medications which includes generic and trade name, indications for usage, dosage with maximum limit, side effects, rate of administration, stability and storage requirements, appropriate diluents, incompatibilities, toxicity, specific precautions and nursing interventions.
3. Prior to administering an I.V. medication, the registered professional I.V. nurse shall be cognizant of the implications of I.V. medication.
4. If an I.V. medication has possible allergic implications, it is recommended that the physician administer the first dose.
5. The approved drug list shall be updated and added to continually.
6. The approved drug list shall be reviewed annually.
7. The patient shall be evaluated for possible drug sensitivity and possible complications prior, during and after I.V. medication administration.
8. Administration of I.V. medications shall be documented in the patient's permanent record.
9. Aseptic technique shall be adhered to in the administration of I.V. medications.

19. **Administration of I.V. Investigational Drugs**
The administration of I.V. investigational drugs shall be initiated by a prescription of a medical doctor with approval of the health care facility and provide a therapeutic outcome.

Recommendations of Practice
1. The administration of I.V. investigational drugs shall be in accordance with the Standards of Practice as stated in the section *Administration of I.V. Medications* under the Recommendations of Practice.
2. The health care facility shall establish specific guidelines, policies and procedures for the administration of I.V. investigational drugs and these guidelines, policies and procedures shall be stated in the I.V. Policy and Procedure Manual.
3. A separate approved list for the use of I.V. investigational drugs shall be employed.
4. All I.V. investigational drugs shall be approved by a hospital committee.
5. I.V. investigational drugs shall be initiated with the patient's consent.
6. I.V. investigational drugs shall be reviewed and monitored by the medical staff.

20. **I.V. Push Medications**
To provide instant absorption of I.V. medications in the blood, immediate therapeutic effect in an emergency situation and for a specific drug peculiarity.

Recommendations of Practice
1. An approved, separate list of I.V. push medications shall be provided by the health care facility and stated in the I.V. Policy and Procedure Manual.
2. The administration of I.V. push medications shall be initiated on the order of a medical doctor or on the judgement of a registered professional I.V. nurse in a life-threatening emergency situation according to the policy of the health care facility.

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3. The administration of I.V. push medications should be in accordance with the Standards of Practice in the section *Administration of I.V. Medications* under the Recommendations of Practice.
4. Special emphasis shall be given to the rate of administration.
5. I.V. push medications shall be diluted sufficiently and according to the manufacturer's recommendations.

21. .22 Micron Air Eliminating Filters

To protect the patient from induced particulates, possible air emboli, pathogenic bacteria (microorganisms) and to minimize the risk of I.V. related complications and sepsis.

Recommendations of Practice

1. The routine use of .22 micron air eliminating filters is advocated in delivering routine I.V. therapy since these filters effectively remove particles and bacteria and prevent air from entering the I.V. system.
2. .22 micron air eliminating filters should be routinely changed every 24-48 hours.
3. Possible retention due to low dosage, solubility and absorption properties of I.V. drugs through a .22 micron air eliminating filter shall be considered and follow the manufacturers' recommendations.
4. Lipid emulsions and blood and blood products shall not be infused through a .22 micron air eliminating filter.
5. The pressure tolerance of the filter housing and membrane shall be a major consideration prior to use.
6. The tolerated psi (pounds per square inch) of a filter shall not exceed the maximum pressure (psi) exerted by the I.V. pump.
7. .22 micron air eliminating filters should be placed at the terminal end of the I.V. administration set (as close to the I.V. cannula as possible).

Considerations

1. This Association believes that the use of .22 micron air eliminating filters is cost justified.
2. From an infection standpoint only, the Centers for Disease Control does not recommend the routine use of .22 micron air eliminating filters. Their recommendation is based on the lack of definitive studies to date, on the efficacy of .22 micron air eliminating filters studying filtration from an infection control standpoint. Such studies are difficult to accomplish. However, there have been many definitive studies attesting to the benefits of final filtration, e.g., minimizing phlebitis which is a precursor to infection and their air elimination properties protecting the patient from air emboli. Since .22 micron air eliminating filters screen out particles, remove microorganisms and prevent air from entering the I.V. system, the National Intravenous Therapy Association believes that many benefits of final filtration have been very well documented in the literature and the use of .22 micron air eliminating filters minimizes potential risk to the patient, thus, the use is recommended routinely for all I.V. therapy. Furthermore, their cost is justified as possibly cost effective by considering possible complications of therapy resulting in possible further medical treatment and longer patient stay days.
3. No I.V. filter is available that will prevent the passage of endotoxins or pyrogens.
4. Consideration should be given to the filter surface area to insure necessary flow rates.
5. Automatic air venting allows air bubbles to escape to the atmosphere.

22. Mechanical Controlling Devices

The use of mechanical controlling devices is to provide minimal deviation from the prescribed medical order in the delivery of solutions and/or medications, thus reducing the risk of possible I.V. complications.

Recommendations of Practice

1. Delivery of all aspects of I.V. therapy shall be controlled with minimal deviation from the prescribed rate ordered.
2. The use of gravity feed mechanical devices, e.g., I.V. controllers is advocated for the majority delivery of I.V. therapy.
3. The use of pressure feed mechanical devices, e.g., I.V. pumps is recommended for controlling I.V. delivery when a specified accuracy of delivery is mandatory due to patient risk.
4. I.V. pumps should maintain I.V. delivery within stringent deviation of the prescribed medical order and their accuracy or deviated limit (plus or minus) shall be stated by the manufacturer.
5. All I.V. electronic devices shall be routinely cleaned and checked for any possible malfunctions.
6. The use of electronic mechanical controlling infusion devices shall be prioritized and stated by hospital policy in the I.V. Policy and Procedure Manual.
7. The registered professional I.V. nurse shall be proficient and knowledgeable in the use of mechanical controlling devices within the health care facility.
8. Operating instructions for electronic mechanical I.V. controlling devices shall be affixed to the device.
9. Audible and visible alarms to detect air, deviated flow, occlusion, and any other deviations placing the patient at risk shall be integrated within the mechanical infusion device.
10. If the mechanical controlling device is battery operated, the life and potency of the battery(s) should be ascertained and changed accordingly.
11. Mechanical electronic controlling devices should be patient tamperproof.

Considerations

1. Consideration should be given to maximum

occlusion pressures. Pumps set at I.V. pump rate exceed.

2. Consideration should be given to accuracy over the range of back pressures.
3. The registered professional I.V. nurse should be cognizant of the Standards on Infusion Devices set forth by the Association for the Advancement of Medical Instrumentation.

23. Blood Component Therapy

The initiation of blood and blood component therapy shall be on the order of a medical doctor and shall provide a safe and therapeutic outcome as prescribed.

Recommendations of Practice

1. The administration of blood and blood components by a registered professional shall be in accordance with federal and state regulations and established hospital policy.
2. The administration of blood and blood components shall only be assumed by the registered professional nurse after successful testing of theory in immunohematology, blood grouping, blood and blood components and reactions, clinical competency of administration techniques and identification protocol of patient and products and nursing interventions for possible reactions shall be validated.
3. Policies and procedures for administration of blood and blood components shall be approved by the Medical Director of the Blood Bank and reviewed annually.
4. The patient may be required, according to established hospital policy, to sign a consent form prior to administering blood and blood component therapy.
5. The patient should be evaluated prior to, during and after blood and blood component administration.
6. All blood and blood products should be inspected prior to use to insure the integrity of the product and product expiration.
7. The physician's order for blood and blood components shall be written clearly and specifically.
8. The patient shall be observed for at least five minutes after the initiation of blood and blood components.
9. Adherence to aseptic technique in the administration of blood and blood components is mandatory.
10. The size of the cannula should be appropriate for accommodating blood or blood components.
11. The registered professional nurse shall be accountable for implementing appropriate intervention on all blood and blood component reactions.
12. Blood and blood products shall not be placed in a unit refrigerator where the temperature(s) are not specifically controlled and regulated for blood and blood products.
13. The use of 170 micron filters is recommended for routine administration of whole and blood components.
14. All initiation, termination and nursing intervention regarding blood and blood components shall be documented in the patient's record.
15. Interchange of blood and blood products shall be stated in established hospital policy.
16. The time for infusing blood or blood components shall be in keeping with the Bureau of Biologics, the American Association of Blood Bank Standards and any exception should be established in hospital policy with approval of the Medical Director of the Blood Bank.
17. The temperature variance for blood and blood products, prior to use, should be in keeping with the American Association of Blood Banks.
18. The use of blood warmers is advocated in certain medical conditions, e.g., Raynaud's Disease or a patient with cold agglutinins. These machines shall be checked routinely for temperature control and any malfunction.
19. Generally, no medication or solution should be added to blood or blood components unless approved by the Medical Director of the Blood Bank and established by hospital policy.
20. I.V. administration sets should be changed after the administration of blood and blood products.
21. When appropriate, I.V. lines should be flushed with saline solutions rather than dextrose solutions prior to and after administering whole blood or red cells since dextrose causes hemolysis of the red cell.
22. Blood and blood products should not be administered in conjunction with other I.V. solutions or interrupted for administration of another I.V. solution.

Considerations

1. The principle governing transfusion therapy is component therapy.
2. The use of fresh blood and blood components minimizes adverse reactions.
3. The use of microaggregate filters (20-40 microns) should be employed when clinically indicated and appropriate.
4. A unit of fresh blood, fresh frozen plasma or platelet concentration should be transfused for every 5-10 units of stored blood given within a 24-hour period.

24. I.V. Chemotherapy

I.V. Chemotherapy shall be initiated by a medical doctor's order for safe administration of I.V. antineoplastic agents in the treatment of cancer.

Recommendations of Practice

1. The administration of antineoplastic agents shall be conducted by the registered professional I.V. nurse who possesses knowledge and understanding of the basic principles of cancer therapy.
2. The administration of I.V. antineoplastic agents

shall be in keeping with the recommendations stated in this document for general I.V. therapy.
3. An approved list of I.V. antineoplastic drugs including investigational agents and a recommendation for their preparation and administration shall be established in hospital policy.
4. Determination of blood values shall be evaluated.
5. A general history and assessment of clinical condition should be noted prior to treatment.
6. Preservation of vascular access is mandatory for providing continued therapy.
7. The choice of cannula shall be determined by the prescribed treatment, duration and condition of patient.
8. Ascertaining placement of the I.V. device to avoid infiltration is mandatory.
9. Drugs classified as vesicants shall be administered in conjunction with a continuous I.V. flow.
10. Appropriate nursing intervention for extravasation of drugs, especially vesicants, shall be employed.
11. Precautions in preparation and administration of antineoplastic agents shall be employed for protection of the patient and medical personnel.
12. The rate of delivery of antineoplastic agents shall be precisely controlled and consideration should be given to the use of I.V. mechanical controlling devices.
13. The use of .22 micron air eliminating filters should be employed unless contraindicated.
14. Assessment for the use of Total Parenteral Nutrition should be employed.
15. Assessment for the use of blood component therapy should be employed.
16. Consent forms shall be mandatory for all I.V. investigational agents.
17. The physical and psychological aspects of I.V. cancer therapy shall be clearly presented and discussed with the patient.
18. Appropriate intervention for possible physical effects, including but not limited to alopecia, weight loss, nausea and vomiting should be employed.

Considerations

1. Consideration should be given to out patient therapy when appropriate.
2. Collaboration with other members of the health care team and local agencies shall be employed for meeting the psychosocial needs of the patient.

25. Documentation of I.V. Therapy

To protect the patient, nurse and health care facility and to retrieve statistical information by written documentation and verification of I.V. practice(s).

Recommendations of Practice

1. All I.V. procedures shall be documented, including but not limited to: initiation, daily monitoring, number of venipuncture attempts, new site changes, patient tolerance and termination of I.V. therapy.
2. Documentation of I.V. therapy shall be established by hospital policy and stated in the I.V. Policy and Procedure Manual.

26. Termination of I.V. Therapy

I.V. therapy is to be terminated on the order of a medical doctor or because of assessed patient complication.

Recommendations of Practice

1. The I.V. cannula shall be removed nearly flush with the skin, with adherence to aseptic technique and minimal trauma to the patient.
2. On removal, I.V. cannulas shall be visually inspected and assessed for length and tip smoothness to ascertain that the complete catheter has been removed.
3. Scissors should not be used around the I.V. cannula site in terminating I.V. therapy.
4. Apply firm pressure immediately after removal.
5. Termination of I.V. therapy should be documented on the patient's record.
6. A dry sterile dressing should be applied over the cannula site and removed in 24 hours.

27. Daily Monitoring of I.V. Therapy

To protect the patient by providing quality assurance with regular and standardized inspection of I.V. therapy. These measures shall reduce or prevent complications and related sepsis.

Recommendations of Practice

1. Peripheral I.V. cannulas should be changed every 48-72 hours.
2. I.V. administration sets should be changed every 24-48 hours and at the time a new container of I.V. solution is initiated.
3. The I.V. cannula site should be gently palpated and inspected for redness, swelling and any signs of sepsis.
4. The patient should be assessed for tolerance and any pain associated with this therapy.
5. The physician's order should be checked and the patient's record should be assessed to insure that the patient has received the prescribed therapy.
6. If the I.V. cannula requires change, a new I.V. access should be established before removal of the existing cannula.
7. If the dressing is changed at a 48-hour interval, the site should be cleaned with 70% isopropyl alcohol or iodopher solution and a topical ointment should be reapplied, if used. A sterile dressing should then be applied.
8. I.V. sites, through an intact dressing and flow rates should be checked at least every 8 hours.
9. Labeling of cannula, dressing, I.V. administration set and solutions should be in accordance with these Standards as stated under the designated Sections.
10. Daily monitoring and care shall be documented in accordance with practices as is stated these Standards.
11. Adherence to strict aseptic technique and

avoidance of touch contamination shall be mandatory in daily monitoring and care.

12. Emphasis shall be placed on minimal manipulations of the I.V. system.

Consideration

Because manipulation and touch contamination are common causes for potential I.V. complications, consideration should be given to not interrupting the I.V. system for 48 hours. Although it has not yet been documented in the literature, it is the belief of this Association that the entire system (cannula, filter, dressing and I.V. administration set), except for I.V. solutions, should remain intact and changed at a 48-hour interval, provided no I.V. related complications are encountered before this time.

28. Quality Assurance

The patient receiving I.V. therapy shall be guaranteed an optimal level of I.V. care. A quality assurance program will maximize quality I.V. care and minimize possible I.V. complications and sepsis and insure proper intervention in a timely manner.

Recommendations of Practice

1. Quality assurance is integrated into all aspects of I.V. therapy including, but not limited to: cannula placement and care, I.V. solution preparation, filter application, I.V. administration set change and dressing change.
2. Quality assurance of I.V. therapy should be in compliance with the Recommendations of Practice in each section of the Standards.
3. All products and packaging of products related to this specialty shall be inspected prior to use for integrity, sterility (if applicable), malfunctions, expirations and any product damaged or questioned shall be unacceptable for use.
4. The registered professional I.V. nurse shall be accountable for implementing appropriate intervention for possible local and/or systemic I.V. complication. Early recognition of signs and symptoms of I.V. complications shall be the basis for appropriate intervention.
5. I.V. care should be documented and a means of retrieving this documented data should be employed.
6. Data should be reviewed periodically with a predetermined criteria to evaluate efficiency, quality, complications and interventions of I.V. care.
7. Professional, specially trained I.V. nursing teams decrease the risk of I.V. related complications and infections and insure an optimal level of I.V. care by providing quality assurance and patient protection.
8. Quality assurance programs of I.V. therapy shall be stated in the I.V. Policy and Procedure Manual.
9. Collaboration with and education of other hospital departments and members of the health care team are necessary to assure implementation of viable quality assurance I.V. program.

29. Pediatrics

To insure safe administration and delivery of I.V. therapy to children, infants, neonates and premature infants.

Recommendations of Practice

1. The registered professional I.V. nurse shall have specialized knowledge of I.V. solution and medication dosages for children, infants, neonates and premature infants.
2. I.V. therapy for the pediatric patient shall follow the Recommendations of Practice set forth in these Standards.
3. A volume control mechanism shall be employed to insure accurate safe delivery of I.V. solutions.
4. The pediatric patient shall be evaluated and assessed more frequently than the adult patient.
5. I.V. policies and procedures shall be specific and categorized with special consideration for each of the following: children, infants, neonates and premature infants.
6. Generally, no more than 500 ml of any I.V. solution should be hung on a pediatric patient.
7. Adequate restraint but maximum mobility is essential in delivering I.V. therapy to the pediatric patient.
8. Psychological approaches should be relative to the pediatric patient in delivering I.V. therapy.

30. Infection Control

To minimize I.V. related sepsis, infection control is integrated into many aspects of I.V. therapy, including, but not limited to: I.V. cannula, I.V. dressings, I.V. solutions, I.V. administration set change and the .22 micron air eliminating I.V. filters. Early recognition of the signs and symptoms of sepsis, as well as awareness that the patient may be a compromised host, will maximize the prevention of sepsis and insure appropriate intervention in a timely manner.

Recommendations of Practice

1. Infection control I.V. practices are implied by the outcome criteria in each section throughout these Standards in the Recommendations of Practice.
2. Suspected related I.V. infections shall be documented and brought to the attention of the attending physician and hospital infection control department.
3. Generally, there should be no interruptions in I.V. lines by add-on devices.
4. I.V. administration set junctions should be secured with a luerlock or junction clasping device.
5. Strict aseptic technique shall be employed when "piggy-back" medications or bolus medications injections are delivered through rubber ports on the I.V. administration set. The injection port

of I.V. administration sets shall be disinfected prior to entry.

6. Assessment of phlebitis should be evaluated as a sign and symptom that precedes a possible I.V. infection.
7. .22 micron air eliminating filters effectively screen all bacteria, reducing the patient's risk of I.V. related sepsis.
8. Frequent manipulation of the I.V. system should be avoided.

Considerations

1. Professional, specially trained I.V. nursing teams decrease I.V. related infections by providing control and technical expertise.
2. Collaboration with hospital infection control personnel is advocated.

31. **Metabolic and General Assessment**

To evaluate the patient's physical and mental status; assess the prescribed I.V. order; recognize and maximize the benefits of I.V. treatment; implement nursing intervention and minimize the risks and potential complications associated with this therapy.

Recommendations of Practice

1. The nursing process should be utilized in assessment.
2. Nursing history of the patient should include the collection of subjective and objective data.
3. The patient should be assessed for mental acuity and any mental changes during therapy should be observed, noted and reported.
4. General physical assessment should include observation of the patient's condition and the condition of hair, skin, nails, weight and mouth.
5. Evaluation of laboratory values and fluid balance should be assessed on a daily basis.
6. Patient allergies shall be documented in the patient record and reported to the attending physician and other members of the health care team.
7. Daily intake and output shall be documented on patient's receiving I.V. therapy.
8. Prescribed infusion and medication should be maintained and delivered as prescribed.
9. Active physical exercise should be encouraged.
10. Passive physical exercise should be employed when necessitated by the patient's condition.
11. The patient's skin turgor should be observed.
12. Dependent/generalized edema should be recognized and reported.
13. The registered professional I.V. nurse should be cognizant of abnormal serum levels of glucose, electrolytes, vitamins and blood cell counts relative to I.V. management.
14. A microdrip I.V. administration set may be employed when delivering low volume infusions that are unassisted by mechanical gravity flow devices.
15. Electronic infusion controlling I.V. devices should be considered for maintaining constant rate of an I.V. infusion.
16. Vital signs should be monitored if warranted by the patient's treatment or condition.
17. A question by a registered professional I.V. nurse on a prescribed order should be clarified by the medical doctor prior to implementing and administering therapy to the patient. Prescribed orders that are questioned should not be carried out.
18. Continuous patient assessments should be made at regular intervals.

32. **Home I.V. Therapy Programs** (Supervised by 1984 Standards SOF 35)

Home I.V. therapy programs are designed for patients who are ready to leave the hospital but require I.V. therapy. Teaching the patient and significant others and follow-up I.V. care by the registered professional I.V. nurse will insure safe I.V. therapy for the home patient.

Recommendations of Practice

1. Written medical orders shall be ascertained for placing a patient on home I.V. therapy.
2. The patient and significant others shall be evaluated for competency and comprehension of the particular I.V. therapeutic regime prior to becoming a candidate for a home I.V. therapy program.
3. All possible complications of the patient's particular treatment shall be discussed and explained with the patient and significant others.
4. A consent form stating understanding and acceptance of possible consequences of I.V. complications shall be signed by the patient.
5. Home I.V. procedures shall be explained and demonstrated to the patient and significant others.
6. Patient and significant others shall return demonstrations of I.V. procedures and aseptic techniques. The competency and proficiency of the patient and significant others shall be evaluated and documented.
7. Patient and significant others shall feel secure with the home I.V. program prior to the patient being discharged.
8. Patient should be discharged with adequate supplies, medications and solutions.
9. Site inspection of the home by the registered professional I.V. nurse may be necessary to ascertain an area in the home for clean storage of supplies and an appropriate area for using sterile supplies.
10. I.V. catheter and I.V. dressings shall be changed as stated in the specific sections of these Standards under Recommendations of Practice.
11. The changing time interval is not known for central I.V. catheters that are considered long term catheters.
12. Peripheral I.V. catheters (excluding those catheters whose tips lie in central vessels) for patients on home I.V. therapy shall be changed every 48-72 hours.
13. I.V. administration sets should be changed at

The National Intravenous Therapy Association's Intravenous Nursing Standards of Practice #10

Editors Note: The following are the "Home I.V. Therapy Nursing Standards of Practice" which have been revised, updated, and approved by the Standards Committee and the NITA Board of Directors. These Home I.V. Therapy Standards replace Section 32 in the existing "Standards of Practice" document. The following Home Standards are applicable to all aspects of I.V. therapy delivered outside the hospital. The entire NITA "Standards" document is in the process of a complete revision and will be expanded. Since the completed revision of the NITA "Standards" will be a lengthy process, and since home I.V. therapy is a growing area of practice, the Board of Directors felt it responsible to publish the "Home I.V. Therapy Nursing Standards of Practice" at this time.

Home I.V. Therapy

Home I.V. therapy standards are written for nurses delivering intravenous care outside of the hospital. The nurses practice shall comply with state laws and all standards set forth by this Association which are applicable to the delivery of home I.V. therapy. The primary goals of home I.V. therapy are to achieve the highest level of self care and quality of life for the patient by providing patient teaching and follow-up nursing care.

1. A physician's order shall be written regarding patient referral(s) for home I.V. therapy.
2. A medical order shall be written and signed by a physician to initiate and direct home I.V. therapy.
3. The written medical order(s) shall be reviewed and updated by the physician routinely.
4. Only physicians shall initiate a verbal medical order(s). Verbal medical order(s) shall be documented immediately by the registered nurse and brought to the physicians attention to be countersigned by the physician as soon as possible.
5. To insure that prescribed care is administered safely, the registered nurse shall have the knowledge and skills to interpret and implement the written medical order.
6. A consent form should be established and signed by the patient and/or legal guardian.
7. The patient shall be assessed for his/her ability to safely administer the prescribed home I.V. therapy.
8. If after the nursing assessment the patient is unable to achieve a determined level of self care, a significant other(s) shall be incorporated into the home I.V. therapy care plan and the physician shall be notified.
9. The significant other(s) shall be assessed for his/her ability to safely administer the prescribed home therapy treatment(s).
10. As the primary educator, the registered nurse shall address indication(s), benefits, methods and risks of therapy.
11. The teaching process for the patient and/or significant other(s) shall include written instructions, verbal explanations, demonstrations, evaluation and documentation of competency, proficiency in performing therapy-related procedures, self-monitoring, scope of physical activities, necessary intervention(s), safe discard of disposable equipment and specific actions to be taken in a possible emergency situation.
12. Therapy specific teaching instructions will be utilized during the educational process and shall be given to and remain with the patient and/or significant other(s).
13. All supplies and equipment necessary for therapy shall be available in the home before therapy is initiated.
14. Supply and equipment needs shall be continuously evaluated and met.
15. By the date of discharge, a registered nurse shall perform a home assessment and assist the patient and/or significant other(s) to determine an appropriate area for clean, safe storage of supplies/equipment, select a suitable area for procedures to be performed, and determine a safe discard of disposable equipment.
16. An ongoing assessment of patient and/or significant other(s) compliance in performing therapy related procedures shall be done at periodic intervals depending on patient condition and therapy.
17. All communications(s) with and/or site visit(s) to the patient shall be documented.
18. A summary of patient care shall be communicated to the physician at regular intervals.
19. Any pertinent observation that requires medical intervention shall be reported to the physician immediately.
20. The patient and/or significant other(s) shall be provided 24 hour access to appropriate health care professional(s).
21. It is recommended that the patient carry and/or wear appropriate identification indicative of therapy.
22. Psycho-social concerns of home I.V. therapy should be evaluated.

APPENDIX

KENTUCKY BOARD OF NURSING
4010 DUPONT CR.-Suite 430
Louisville, Kentucky 40207
(502) 897-5143

OPINION

Roles of Nurses in Intravenous Therapy Practice

The primary mission of the Kentucky Board of Nursing, performed through the regulation of nurses and nursing education and practice, is to protect the public, and to assure that safe and effective nursing care is provided by nurses for the citizens of the Commonwealth. In order to protect and safeguard the health and safety of the citizens who receive intravenous therapy and to address the numerous inquiries relative to the scope of nursing practice in intravenous therapy/procedures, it is necessary to define the appropriate roles of nurses in intravenous therapy practice.

Numerous inquiries regarding intravenous therapy practice have been received by the Board. The minutes of the past Kentucky Board of Nursing meetings document that there has been ongoing study of the roles of nurses in intravenous therapy practice and that the Board has issued opinions relative to this matter since 1976. In June, 1982, the Board constituted a Practice Committee, composed of persons representing various areas of the Commonwealth and various kinds of nursing practice settings, to study and make recommendations regarding the appropriate roles of nurses in intravenous therapy practice. The Practice Committee's research of this issue included extensive review of standards of nursing practice, curricula of Board approved nursing education programs in the Commonwealth, and laws governing nursing practice. Relevant sections of the Kentucky Revised Statutes Chapter 314 (Kentucky Nursing Practice Act) include the following:

> Section 314.011(5) "Registered nursing practice" shall mean the performance of acts requiring substantial specialized knowledge, judgment and nursing skill based upon the principles of psychological, biological, physical and social sciences in the application of the nursing process in:
>
> a) the care, counsel and health teaching of the ill, injured or infirm.
>
> b) the maintenance of health or prevention of illness of others.

c) the administration of medication and treatment as prescribed by a physician or dentist licensed in this state and as further authorized or limited by the Board, and which are consistent either with the American Nurses' Association standards of practice or with standards of practice established by nationally accepted organizations of registered nurses.

d) the supervision and teaching of other personnel in the performance of activities relating to nursing care.

e) the performance of other nursing acts which are authorized or limited by the Board, and which are consistent either with the American Nurses' Association standards of practice or with standards of practice established by nationally accepted organizations of registered nurses.

Section 314.011(9) "Licensed practical nursing practice" shall mean the performance of acts requiring the knowledge and skills such as - are taught or acquired in approved schools for practical nursing in:

a) the observing and caring for the ill, injured or infirm under the direction of a registered nurse, a licensed physician or dentist.

b) the giving of counsel and applying procedures to safeguard life and health, as defined and authorized by the Board.

c) the administration of medication or treatment as authorized by a physician or dentist licensed in this state and as further authorized or limited by the Board which are consistent with the National Federation of Licensed Practical Nurses or with standards of practice established by nationally accepted organizations of licensed practical nurses.

d) teaching or supervising except as limited by the Board.

e) the performance of other nursing acts which are authorized or limited by the Board and which are consistent with the National Federation of Licensed Practical Nurses' standards of practice established by nationally accepted organizations of licensed practical nurses.

Section 314.011(11) "Continuing education" shall mean participation in approved offerings beyond the basic nursing education program that present specific content planned and evaluated to meet competency based behavioral objectives which develop new skills and upgrade knowledge.

Section 314.021(2) All individuals licensed under provisions of this chapter shall be responsible and accountable for making decisions that are based upon the individuals' educational preparation and experience in nursing.

In accordance with these sections of KRS Chapter 314 and after study of the issue, the Practice Committee identified three categories of intravenous therapy practice. After review of the Practice Committee's study and recommendation, it was the opinion of the Board that the practice of the registered nurse and the licensed practical nurse be guided by the three categories as herein defined.

Category I: Because of the knowledge and skills acquired in approved programs for practical nursing, the licensed practical nurse may perform the following procedures upon successful completion of a Board approved practical nursing program and licensure and under the supervision* of a registered nurse, physician or dentist:

1. Perform simple calculation and adjust flow rate.

2. Observe and report subjective and objective signs of adverse reactions to IV administration.

3. Inspect insertion site, change dressing and remove intravenous needle or catheter from peripheral veins except as limited** by the Board.

Category II: Because the curricula taught in approved programs for practical nursing provide the basic background knowledge for the licensed practical nurse to develop new skills and upgrade knowledge through continuing education, the licensed practical nurse may perform the following procedures upon successful completion of a Board approved continuing education course for intravenous therapy/procedures and under the supervision* of a registered nurse, physician or dentist:

1. Perform venipuncture to withdraw blood from peripheral veins except as limited** by the Board.

2. Perform venipuncture to start intravenous fluids in peripheral veins except as limited** by the Board.

3. Perform venipuncture to start the following IV fluids - D_5W, D_5NS, $D_5\frac{1}{2}NS$, $D_5\frac{1}{4}NS$, NS, $\frac{1}{2}NS$, $\frac{1}{4}NS$ in peripheral veins except as limited** by the Board.

4. Hang the following IV fluids - D_5W, D_5NS, $D_5\frac{1}{2}NS$, $D_5\frac{1}{4}NS$, NS, $\frac{1}{2}NS$, $\frac{1}{4}NS$ to pre-existing venipunctures in peripheral veins except as limited** by the Board.

5. Change IV administration set except as limited** by the Board.

Category III: The registered nurse may perform all procedures in Categories I and II. Because the basic curricula taught in approved programs for registered nursing include the in-depth application of principles of psychological, biological, physical and social sciences for the performance of those acts requiring substantial specialized knowledge, judgment and nursing skills, only the registered nurse may perform, but is not limited to, the following intravenous procedures:

1. Hang blood or blood components.

2. Hang solution for intravenous parenteral nutrition, e.g. hyperalimentation or similar solution.

3. Administer medication via intravenous route:

   a. Add medication to an intravenous solution.

   b. Hang piggy back infusions.

   c. Inject medication into an auxillary fluid chamber, e.g. volutrol, buretrol.

   d. Inject medication via direct intravenous route, e.g. bolus, push.

4. Flush or aspirate an IV line, arterial line, needle or catheter.

5. Change dressing, IV administration set or remove an intravenous cannula from the following: femoral, subclavian, or jugular vein, any venous or arterial site in which a central line is inserted or any arterial site or cut-down site.

6. Change dressing, IV administration set or remove an intravenous cannula when the peripheral cannula must remain in place for prolonged periods (>72 hours) or the patient has an unexplained fever and/or there is pain or tenderness at the site of insertion, or other signs of cannula related infection, phlebitis or other complications from IV administration.

*"Supervision" shall mean immediately available to assess and evaluate patient response(s) and to assess, direct and evaluate nurse performance.

**"Except as limited" shall mean the specified IV procedure shall not be performed when the following sites/procedures are used for IV administration: femoral, subclavian or jugular vein; any peripheral vein in which a central line is inserted, any arterial site/line, any central line insertion procedure or cut-down procedure.

Effective July 1, 1984.

as

DESCRIPTION OF KENTUCKY

ADVANCE DIRECTIVE LAW

In compliance with the mandate for Kentucky to develop a written description of its statutory and case law concerning advance directives, this office presents such a description below, which is based on statutory law, there being no case law which has specifically addressed the issue.

KENTUCKY LAW ON ADVANCE DIRECTIVES FOR MEDICAL DECISIONS

THE KENTUCKY LIVING WILL ACT

The 1990 session of the Kentucky General Assembly passed and the Governor signed into law House Bill No 113, known as the Kentucky Living Will Act, which is codified at KRS 311.622-644 and now sanctions the right of adult Kentuckians of sound mind to execute a written declaration which would allow life-prolonging treatments to be withheld or withdrawn in the event they become terminally ill and can no longer participate in making decisions about their medical care. The living will must be signed by the declarant in the presence of two subscribing witnesses who must not be blood relatives who would be beneficiaries of the declarant, beneficiaries of the declarant under the descent and distribution statutes of Kentucky, an employee of a health care facility in which the declarant is a patient, an attending physician of the declarant, or any person directly financially responsible for the declarant's health care. The living will must be notarized.

Two physicians, one of whom being the patient's attending physician, would have to certify that the declarant's condition was terminal before the living will could be implemented. The living will would not allow for the withholding or withdrawal of food or water, or medication or medical procedures deemed necessary to alleviate pain, and it would not apply to pregnant women.

THE HEALTH CARE SURROGATE ACT OF KENTUCKY

Also enacted into law by the 1990 session of the Kentucky General Assembly and the Governor was Senate Bill No. 88, the Health Care Surrogate Act of Kentucky, which is codified at KRS 311.970-986 and allows an adult of sound mind to make a written declaration which would designate one or more adult persons who could consent or withdraw consent for any medical procedure or treatment relating to the grantor when the grantor no longer has the capacity to make such decisions. This law requires that the grantor, being the person making the designation, sign and date the designation of health care surrogate which, at his option, may be in the presence of two adult witnesses who also sign or he may acknowledge his designation before a notary public without witnesses. The health care surrogate cannot be an employee, owner, director or officer of a health care facility where the grantor is a resident or patient unless related to the grantor.

Except in limited situations, a health care facility would remain obligated to provide food and water, treatment for the relief of pain, and life sustaining treatment to pregnant women, notwithstanding the decision of the patient's health care surrogate.

DURABLE POWER OF ATTORNEY

A person may execute, pursuant to KRS 386.093, a document known as a durable power of attorney which would allow someone else to be designated to make decisions regarding health, personal, and financial affairs notwithstanding the later disability or incapacity of the person who executed the durable power of attorney.

PREPARED BY:

THE CABINET FOR HUMAN RESOURCES
OFFICE OF GENERAL COUNSEL
APRIL 22, 1991

Living Will Declaration

APPENDIX XIX

Declaration made this _____ day of _____(month), _____ (year). I, _____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending and one (1) other physician in their discretion, have determined such condition is incurable and irreversible and will result in death within a relatively short time, and where the application of life-prolonging treatment would serve only to artificially prolong the dying process, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain or for nutrition or hydration.

In the absence of my ability to give directions regarding the use of such life-prolonging treatment, it is my intention that this declaration shall be honored by my attending physician and my family as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

State of Kentucky)
)Sct.
County of _____)

Before me, the undersigned authority, on this day personally appeared _____, Living Will Declarant, and _____ and _____, known to me to be witnesses whose names are each signed to the foregoing instrument, and all these persons being first duly sworn, _____, Living Will Declarant, declared to me and to the witnesses in my presence that the instrument is the Living Will Declaration of the declarant and that the declarant has willingly signed and that such declarant executed it as a free and voluntary act for the purposes therein expressed; and each of the witnesses stated to me, in the presence and hearing of the Living Will Declarant, that the declarant signed the declaration as witnessed, and to the best of such witnesses' knowledge, the Living Will Declarant was eighteen(18) years of age or over, of sound mind and under no constraint or undue influence.

_____
Living Will Declarant

_____
Witness

_____
Address

_____
Witness

_____
Address

Subscribed, sworn to and acknowledged before me by _____, Living Will Declarant, and subscribed and sworn before me by _____ and _____, witnesses, on this the _____(day) of _____(month), _____(year).

DESIGNATION OF HEALTH CARE SURROGATE

I DESIGNATE_____ AS MY HEALTH CARE SURROGATE(S) TO MAKE ANY HEALTH CARE DECISIONS FOR ME WHEN I NO LONGER HAVE DECISIONAL CAPACITY. IF _____ REFUSES OR IS NOT ABLE TO ACT FOR ME, I DESIGNATE _____ AS MY HEALTH CARE SURROGATE(S).

ANY PRIOR DESIGNATION IS REVOKED.

SIGNED THIS _____ DAY OF _____, 19_____

_____

SIGNATURE AND ADDRESS OF THE GRANTOR

IN OUR JOINT PRESENCE, THE GRANTOR, WHO IS OF SOUND MIND AND EIGHTEEN YEARS OF AGE, OR OLDER, VOLUNTARILY DATED AND SIGNED THIS WRITING OR DIRECTED IT TO BE DATED AND SIGNED FOR THE GRANTOR.

_____

SIGNATURE AND ADDRESS OF WITNESS

_____

SIGNATURE AND ADDRESS OF WITNESS

COMMONWEALTH OF KENTUCKY

_____ COUNTY

BEFORE ME, THE UNDERSIGNED AUTHORITY, CAME THE GRANTOR WHO IS OF SOUND MIND AND EIGHTEEN (18) YEARS OF AGE, OR OLDER, AND ACKNOWLEDGED THAT HE VOLUNTARILY DATED AND SIGNED THIS WRITING OR DIRECTED IT TO BE SIGNED AND DATED AS ABOVE.

DONE THIS _____ DAY OF _____, 19_____

_____

SIGNATURE OF NOTARY PUBLIC

DATE COMMISSION EXPIRES: _____

ADVANCE DIRECTIVE

ACKNOWLEDGMENT

NAME:_____ DATE OF BIRTH: _____

SOC. SEC.#:_____

PLEASE READ THE FOLLOWING FIVE STATEMENTS:

Place your initials after <u>each</u> statement.

1. I have been given written materials about my right to accept or refuse medical treatment. _____(Initialed)
2. I have been informed of my right to formulate advance directives. _____(Initialed)
3. I understand that I am not required to have an advance directive in order to receive medical treatment. _____(Initialed)
4. I understand that the terms of any advance directive that I have executed will be followed by my caregivers to the extent permitted by law. _____(Initialed)
5. I understand that I can change my mind at any time and that my decision will not result in the withholding of any benefits or medical services. _____(Initialed)

PLEASE CHECK <u>ONE</u> OF THE FOLLOWING STATEMENTS:

☐ I HAVE EXECUTED AN ADVANCE DIRECTIVE.

☐ I HAVE NOT EXECUTED AN ADVANCE DIRECTIVE.

_____ DATE: _____
Patient/Guardian

_____ DATE: _____
Health Care Provider Representative

PATIENT SELF-DETERMINATION PROTOCOL FOR CERTIFIED HEALTH CARE PROVIDERS

1. The Certified Health Care Provider shall inform all adult patients, in writing and orally, of information under Kentucky Law concerning their right to make decisions relative to their medical care.

2. The Certified Health Care Provider shall present each adult patient with a written copy of the agency's policy concerning implementation of their rights.

3. The Certified Health Care Provider shall not condition the provision of care or otherwise discriminate against any patient based on whether the patient has executed an advance directive.

4. The Certified Health Care Provider shall document in the patient's medical record whether or not the patient has executed an advance directive.

5. The Certified Health Care Provider shall ensure compliance with requirements of Kentucky Law concerning advance directives.

6. The Certified Health Care Provider shall educate all agency staff and the general public concerning advance directives.

PATIENT SELF-DETERMINATION

Policy:

Advise all adult patients (a person eighteen [18] years of age or older and who is of sound mind) of their rights concerning advance directives. (According to provider type, i.e., admission, start of care, etc.)

Purpose:

1. To assure individuals understand they have the right to:
    a. Accept or refuse medical or surgical treatment; and
    b. Formulate advance directives.

Procedure:

Each Certified Health Care Provider shall:

1. Designate a person or persons responsible for informing adult patients of their right to make decisions concerning their medical care.
2. Distribute to each adult patient the following information:
    a. The Cabinet for Human Resources ' description of Kentucky Laws on Advance Directives.
    b. Agency policy regarding implementation of advance directives.

NOTE: Recommend distribution of additional information to assist patients and/or staff in understanding advance directives. The following materials are acceptable:

"Advance Directives Issues and Answers"
Hospice of the Bluegrass

"Advance Directives, Living Will, Health Care Surrogate, Durable Power of Attorney" Video
Hospice of the Bluegrass

"About Advance Medical Directives"
Channing Bete Co., Inc.

"Living Will"
Division of Aging Services

PATIENT SELF-DETERMINATION (Continued)

"Planning For Difficult Times - Tomorrow's Choices"
"Planning For Difficult Times - A Matter of Choice"
American Association of Retired Persons

3. Maintain *Living Will* and *Designation of Health Care Surrogate* documents for distribution to adult patients upon request.

4. Documentation supporting compliance with the requirements regarding non-discriminatory care shall be incorporated into the Quality Assurance process.

5. Documentation supporting the patient's decision to formulate an advance directive shall be included in the medical record. (Recommend use of attached *Advance Directive Acknowledgment* Form.) A process shall be developed to assure appropriate staff are advised of the patient's directive.

6. Documentation supporting all aspects of the staff and general public education campaign shall be recorded by appropriate personnel.

7. Stipulate by policy, family members or guardians will be provided with information regarding advance directives when the patient is comatose or otherwise incapacitated and unable to receive the information. Once he or she is no longer incapacitated the information must be provided directly to the adult patient.

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CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-B

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(FRONT OF CARD)

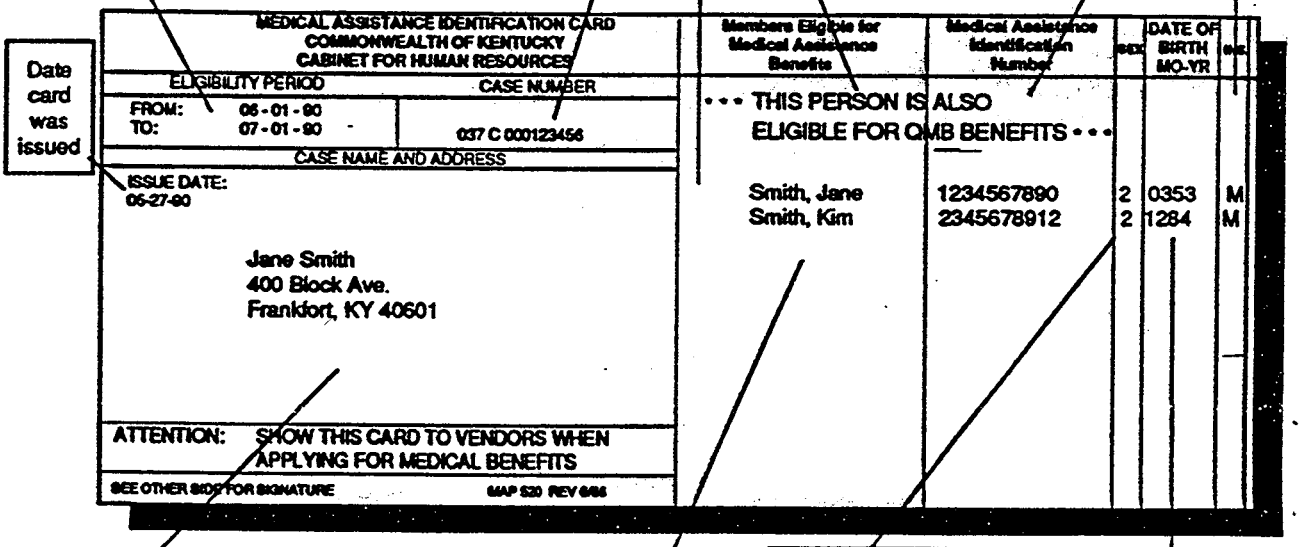
Eligibility period is the month, day and year of Kentucky Medicaid eligibility represented by this card. " From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

NOTICE QMB Info.



Date card was issued

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For Kentucky Medicaid Program Statistical Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for Kentucky Medicaid benefits.

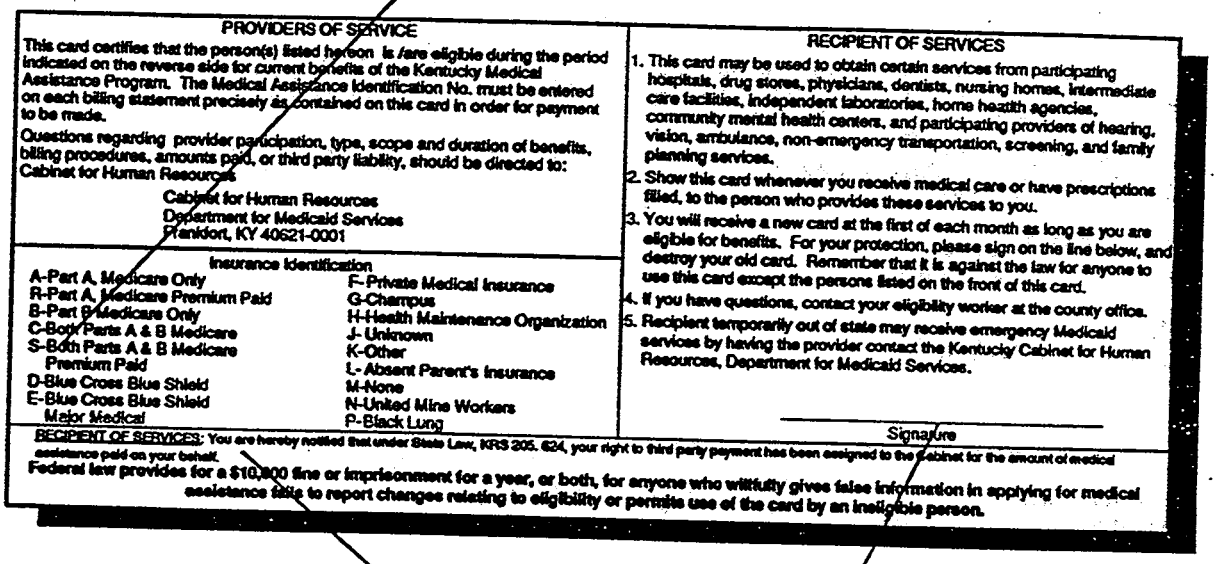
Date of Birth shows month and year of birth of each member . Refer to this block when providing services limited to age.

WHITE CARD (ALSO)

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(BACK OF CARD)

Information to Providers. Insurance Identification codes indicate type of insurance coverage as shown on the front of the card in "Ins." block.



PROVIDERS OF SERVICE

This card certifies that the person(s) listed hereon is /are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources

Cabinet for Human Resources
Department for Medicaid Services
Frankfort, KY 40621-0001

Insurance Identification

A-Part A Medicare Only
R-Part A Medicare Premium Paid
B-Part B Medicare Only
C-Both Parts A & B Medicare
S-Both Parts A & B Medicare Premium Paid
D-Blue Cross Blue Shield
E-Blue Cross Blue Shield Major Medical
F-Private Medical Insurance
G-Champus
H-Health Maintenance Organization
J-Unknown
K-Other
L-Absent Parent's Insurance
M-None
N-United Mine Workers
P-Black Lung

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205. 624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-C

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of QMB eligibility represented by this card.
" From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

Medical Insurance Code indicates type of insurance coverage.

Red

Blue

LIMITED MEDICAID FOR QUALIFIED MEDICARE BENEFICIARIES
IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ELIGIBLE RECIPIENT AND ADDRESS	ELIGIBILITY PERIOD	COVERAGE IS LIMITED TO:
Jane Smith 400 Block Ave. Frankfort, KY 40601	FROM: TO: MEDICAID OMB ID. NO. SEX CODE INSURANCE ID. DATE OF BIRTH MONTH/YEAR	★ MEDICARE PART A PREMIUMS ★ MEDICARE PART B PREMIUMS ★ MEDICARE CO-INSURANCE ★ MEDICARE DEDUCTIBLES SEE REVERSE SIDE FOR ADDITIONAL INFORMATION
ATTENTION: SHOW THIS CARD TO VENDORS WHEN SEEKING MEDICAL CARE		PLEASE SIGN IMMEDIATELY
MAP 520-C REV (6-89)		

Name of member eligible to be a Qualified MedicareBeneficiary. Only the person whose name is in this block is eligible for Q.M.B. benefits.

Date of Birth shows month and year of birth of eligible individual.

RED, WHITE, AND BLUE CARD

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-C

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B) CARD

(BACK OF CARD)

Information to Providers. including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through QMB.

PROVIDERS OF SERVICE

1. The individual named on this card is a qualified Medicare beneficiary and is eligible for Medicaid payment for Medicare part A and Part B Co-Insurance and Deductables only.
2. Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:

Cabinet for Human Resources
Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621-0001

Insurance Identification

A-Part A, Medicare Only
R-Part A, Medicare Premium Paid
B-Part B Medicare Only
C-Both Parts A & B Medicare
S-Both Parts A & B Medicare Premium Paid
D-Blue Cross Blue Shield
E-Blue Cross Blue Shield Major Medical
F-Private Medical Insurance
G-Champus
H-Health Maintenance Organization
J- Unknown
K-Other
L- Absent Parent's Insurance
M-None
N-United Mine Workers
P-Black Lung

RECIPIENT OF SERVICES

1. Show this card whenever you receive Medical Care.
2. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the front of the card immediately.
3. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.
4. If you have questions, contact your case worker at the Department for Social Insurance County office.

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-D

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM

(FRONT OF CARD)

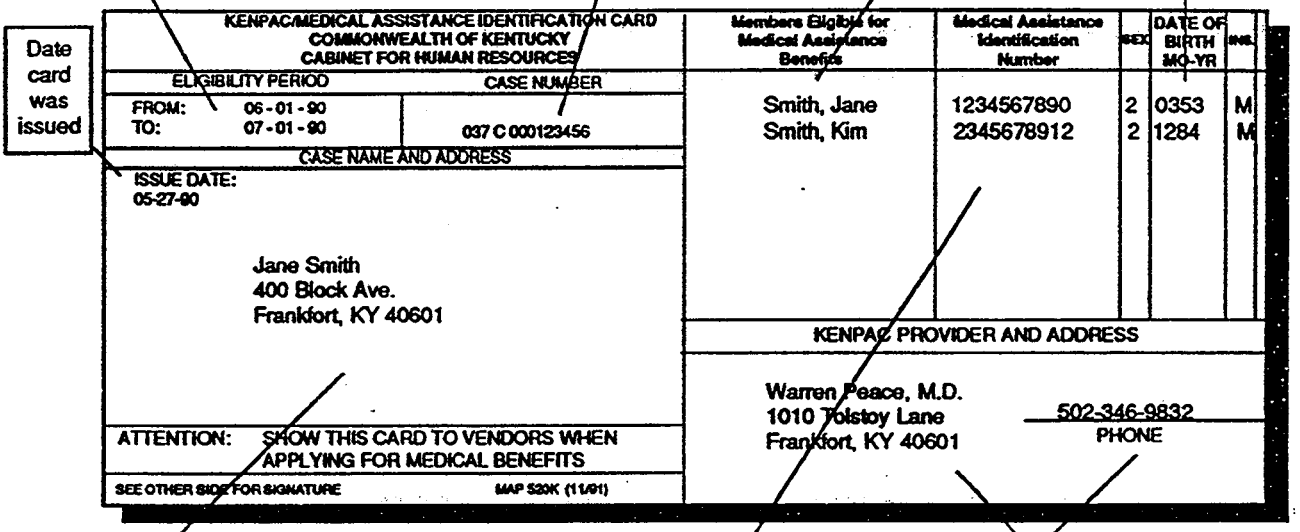
Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care provider listed on this card.

Department for Social Insurance case number.
This is NOT the Medical Assistance Identification Number

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

Names of members eligible for Kentucky Medicaid. Persons whose names are in this block have the Primary Care provider listed on this card.

Date card was issued



KENPAC/MEDICAL ASSISTANCE IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ELIGIBILITY PERIOD
FROM: 06-01-90
TO: 07-01-90

CASE NUMBER
037 C 000123456

CASE NAME AND ADDRESS

ISSUE DATE:
05-27-90

Jane Smith
400 Block Ave.
Frankfort, KY 40601

ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS

SEE OTHER SIDE FOR SIGNATURE MAP 520K (11/91)

Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	SEX	DATE OF BIRTH MO-YR	INS.
Smith, Jane	1234567890	2	0353	M
Smith, Kim	2345678912	2	1284	M

KENPAC PROVIDER AND ADDRESS

Warren Peace, M.D.
1010 Tolstoy Lane
Frankfort, KY 40601

502-346-9832
PHONE

Case name and address show to whom the card is mailed. This person may be that of a relative or other interested party and may not be an eligible member.

Name, address and phone number of the Primary Care provider.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

GREEN CARD

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

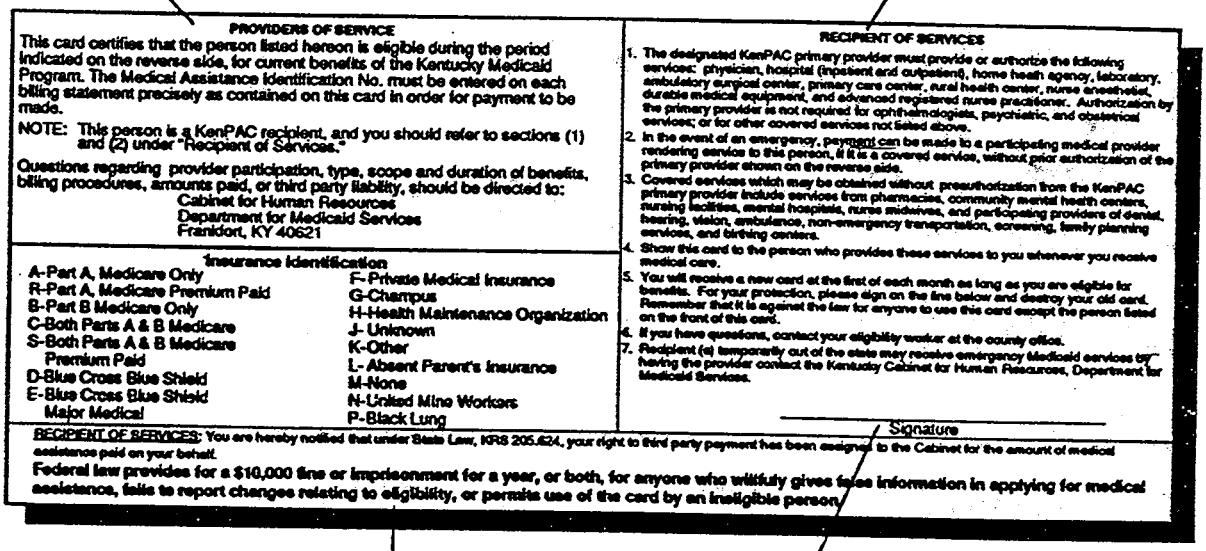
APPENDIX II-D

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM

(BACK OF CARD)

Information to Providers. including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through the KenPAC system.



PROVIDERS OF SERVICE

This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medicaid Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

NOTE: This person is a KenPAC recipient, and you should refer to sections (1) and (2) under "Recipient of Services."

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:
Cabinet for Human Resources
Department for Medicaid Services
Frankfort, KY 40621

Insurance Identification

A-Part A, Medicare Only
R-Part A, Medicare Premium Paid
B-Part B Medicare Only
C-Both Parts A & B Medicare
S-Both Parts A & B Medicare Premium Paid
D-Blue Cross Blue Shield
E-Blue Cross Blue Shield Major Medical
F-Private Medical Insurance
G-Champus
H-Health Maintenance Organization
J-Unknown
K-Other
L-Absent Parent's Insurance
M-None
N-United Mine Workers
P-Black Lung

RECIPIENT OF SERVICES

1. The designated KenPAC primary provider must provide or authorize the following services: physician, hospital (inpatient and outpatient), home health agency, laboratory, ambulatory surgical center, primary care center, rural health center, nurse anesthetist, durable medical equipment, and advanced registered nurse practitioner. Authorization by the primary provider is not required for ophthalmologists, psychiatric, and obstetrical services; or for other covered services not listed above.
2. In the event of an emergency, payment can be made to a participating medical provider rendering service to this person, if it is a covered service, without prior authorization of the primary provider shown on the reverse side.
3. Covered services which may be obtained without preauthorization from the KenPAC primary provider include services from pharmacies, community mental health centers, nursing facilities, mental hospitals, nurse midwives, and participating providers of dental, hearing, vision, ambulance, non-emergency transportation, screening, family planning services, and birthing centers.
4. Show this card to the person who provides these services to you whenever you receive medical care.
5. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.
6. If you have questions, contact your eligibility worker at the county office.
7. Recipient (s) temporarily out of the state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who wilfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-E

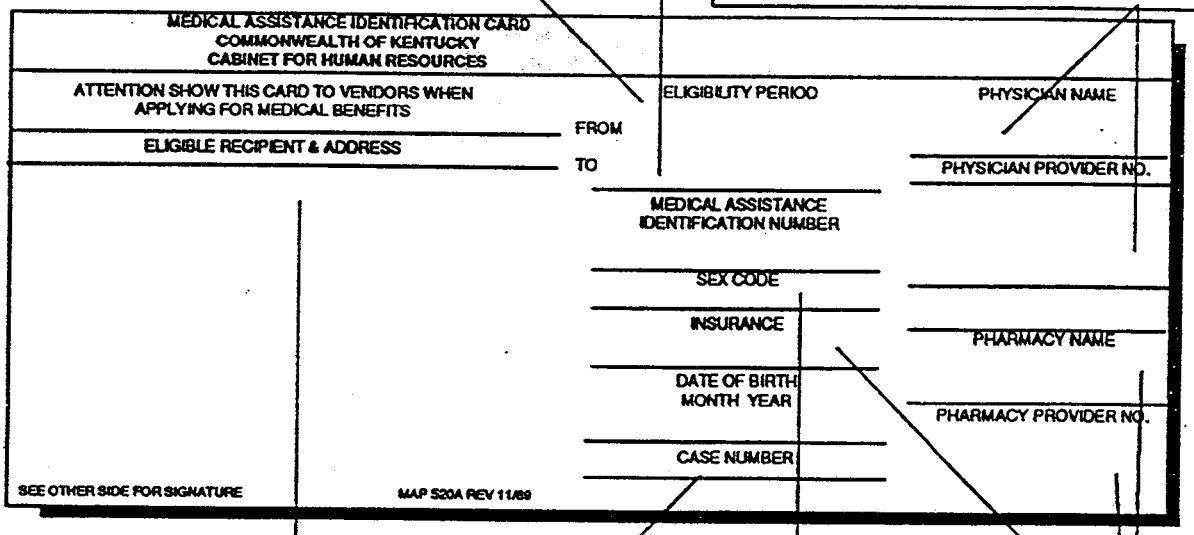
KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Name and provider number of Lock-In physician. Kentucky Medicaid payments will be limited to this physician (with the exception of emergency services and physician referral unless otherwise authorized by the Kentucky Medicaid Program.



Name and address of member eligible for Medical Assistance benefits. All eligible individuals in the Lock-In Program will receive a separate card.

Currently Left Blank

Insurance Code

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

Name, address, and provider number of Lock-In pharmacy. Payment for pharmacy services is limited to this pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

PINK CARD

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-E

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers, including procedures for emergency treatment, and identification of insurance as shown on the front of the card in "Ins." block.

ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person if it is a covered service. The patient is not restricted with regard to other services, however, payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services. Questions regarding scope of services should be directed to the Lock-In Coordinator by calling 502-564-6560.

You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Insurance Identification

A-Part A Medicare Only
R-Part A, Medicare Premium Paid
B-Part B Medicare Only
C-Both Parts A & B Medicare
S-Both Parts A & B Medicare Premium Paid
D-Blue Cross Blue Shield
E-Blue Cross Blue Shield Major Medical
F-Private Medical Insurance
G-Champus
H-Health Maintenance Organization
J-Unknown
K-Other
L-Absent Parent's Insurance
M-None
N-United Mine Workers
P-Black Lung

I have read the above information and agree with the procedures as outlined and explained to me

Signature of Recipient or Representative _____ Date _____

RECIPIENT OF SERVICES

Federal law provides for a $10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

MAP-343 (Rev. 5/86)

APPENDIX III

Provider Number: _____
(If Known)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19___, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

_____
(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

_____
(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

(a) name;
(b) ownership;
(c) licensure/certification/regulation status; or
(d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the event that the Provider is a specialty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate in the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Statement of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19___, with conditional termination on _____, 19___, and shall automatically terminate on _____, 19___, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

MAP-343 A
(11/91)

APPENDIX III

CERTIFICATION ON LOBBYING
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

The undersigned Second Party certifies, to the best of his or her knowledge and belief, that for the preceding contract period, if any, and for this current contract period:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

SIGNATURE: _____

NAME: _____

TITLE: _____

DATE: _____

MAP-344 (Rev. 3/91)

Kentucky Medicaid Program

Provider Information

1. _____ _____
(Name) (County)

2. _____
(Location Address, Street, Route No, P.O. Box)

3. _____
(City) (State) (Zip)

4. _____
(Office Phone# of Provider)

5. _____
(Pay to, In care of, Attention, etc. If different from above address.)

6. _____
Pay to address (If different from above)

7. Federal Employee ID No. _____

8. Social Security No. _____

9. License No. _____

10. Licensing Board (If applicable): _____

11. Original license date: _____

12. Kentucky Medicaid Provider No. (If known) _____

13. Medicare Provider No. (If applicable) _____

14. Practice Organization/Structure: _____ (1) Corporation
_____ (2) Partnership ____(3) Individual
_____ (4) Sole Proprietorship ____ (5) Public Service Corporation
_____ (6) Estate/Trust ____ (7) Government/Non-Profit

15. Are you a hospital based physician (salaried or under contract by a hospital)? ____ yes ____ no
Name of hospital(s) _____

16. If group practice, number of providers in group (specify provider type):

_____

17. If corporation, name, address, and telephone number of corporate office:

_____

_____

Telephone No:_____

Name and address of officers:

_____

_____

_____

_____

18. If partnership, name and address of partners:

_____

_____

_____

_____

19. National Pharmacy No. (If applicable): _____
(Seven-digit number assigned by the National Council for Prescription Drug Programs.)

20. Physician/Professional Specialty Certification Board (submit copy of Board Certificate):

1st _____ Date _____

2nd _____ Date _____

21. Name of Clinic(s) in which Provider is a member:

1st _____

2nd _____

3rd _____

4th _____

22. Control of Medical Facility:

___ Federal ___ State ___County ___City

___ Charitable or religious

___ Proprietary (Privately-owned) ___ Other

23. Fiscal Year End: _____

24. Administrator : _____ Telephone No. _____

25. Assistant Admin: _____ Telephone No. _____

26. Controller: _____ Telephone No. _____

27. Independent Accountant or CPA: _____
Telephone No. _____

28. If sole proprietorship, name, address, and telephone number of owner:
_____
_____

29. If facility is government owned, list names and addresses of board members:

President or Chairman of Board:
_____

Member: _____

Member: _____

30. Management Firm (If applicable):
_____

31. Lessor (If applicable):
_____

32. Distribution of beds in facility:

	Total Licensed Beds	Total Kentucky Medicaid Certified Beds
Acute Care Hospital	_____	_____
Psychiatric Hospital	_____	_____
Nursing Facility	_____	_____
MR/DD	_____	_____

33. NF or MR/DD owners with 5% or more ownership:

Name	Address	% of Ownership

34. Institutional Review Committee Members (If applicable):

_____

_____

35. Providers of Transportation Services:
Number of Ambulances in Operation:____
Number of Wheelchair Vans in Operation: ____
Basic Rate $_____ (Includes up to ___ miles)
Per Mile $_____ Oxygen $_____
Extra Patient $_____ Other $_____

36. Has this application been completed as the result of a change of ownership of a previously enrolled Medicaid provider? ____ yes ____ no

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medicaid Program.

Signature: _____

Name: _____

Title: _____

Return all enrollment forms, changes and inquiries to:

Medicaid-Provider Enrollment
Third Floor East
275 East Main Street
Frankfort, KY 40621

INTER-OFFICE USE ONLY
License Number Verified through _____ (Enter Code)

Comments: _____

_____

Date: _____ Staff: _____

MAP-246 (Rev. 04/91) APPENDIX IV

Agreement Between the
Kentucky Medicaid Program
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The _____ has
(Name of Billing Agency)

entered into a contract with _____,
(Name of Provider)

_____, to submit claims via electronic media for services provided to
(Provider Number)

KMP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;

2. To maintain or have access to a record of all claims submitted for payment for a period of at least five (5) years, and to provide this information to the KMP or designated agents of the KMP upon request;

3. To submit claim information as directed by the provider, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.

4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;

2. To reimburse the provider in accordance with established policies.

This agreement may be terminated upon written notice by either party without cause.

_____
Signature, Authorized Agent of Billing Agency

Date:_____

Contact Name:_____

Telephone No.:_____

Software Vendor
and/or Billing Agency:_____

Media:_____

_____
Signature, Representative of the
Department for Medicaid Services

Date:_____

MAP-380 (Rev. 04/90)

APPENDIX V

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Agreement Electronic Media Addendum

This addendum to the Provider Agreement is made and entered into as of the ____ day of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____,
Name and Address of Provider
hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as a

_____, _____
(Type of Provider and/or Level of Care) (Provider Number)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

   A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP.

   B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent.

   C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media:

   "This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal and State Law."

D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet.

E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.

F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.

G. Agrees to refund to the State the processing fee incurred for processing any electronic media billing submitted with an error rate of 25% or greater.

2. The Cabinet:

A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies.

B. Agrees to assign to the provider or its agent a code to enable the media to be processed.

C. Reserves the right of billing the provider the processing fee incurred by the Cabinet for all claims submitted by any electronic media billing that are found to have a 25% or greater error rate.

Either party shall have the right to terminate this Addendum upon written notice without cause.

PROVIDER

BY:_____
Signature of Provider

Contact Name:_____

Title:_____

Date:_____

Telephone No.:_____

Software Vendor
and/or Billing Agency:_____

Media:_____

CABINET FOR HUMAN RESOURCES
Department for Medicaid Services

BY:_____
Signature of Authorized Official
or Designee

Name:_____

Title:_____

Date:_____

MAP-34
11/87

APPENDIX VI

Commonwealth of Kentucky
Cabinet for Human Resources
Department for Medicaid Services

HOME HEALTH AGENCY CERTIFICATION

_____ (Name of Agency)

_____ (Name of Patient)

_____ (Vendor #)

_____ (County)

Date of Service _____ (Month) _____ (Year)

_____ (City)

_____ (State)

This document serves to certify that benefits for Home Health Agency services have been utilized to the full extent of Title XVIII benefits under Part A and Part B and that the request for Program payment represents the Home Health Agency Services provided after exhaustion of benefits available under Title XVIII for the above-referenced program recipient.

I certify the above information is true, complete and correct to the best of my knowledge and belief.

Rejected by Title XVIII (Provide explanation in space to the right of the box) ☐ Explanation: _____

Rejected by Utilization Review Mechanism (Provide explanation in space to the right of the box) ☐ Explanation: _____

_____
Authorized Home Health Agency Representative

(REV. 7/91)

THIRD PARTY LIABILITY LEAD FORM

Recipient Name : _____ MAID # _____

Date of Birth : _____ Address: _____

Date of Service : _____ To: _____

Date of Admission: _____ Date of Discharge: _____

Name of Insurance Company: _____

Address: _____

Policy #: _____ Start Date: _____ End Date: _____

Date Filed with Carrier: _____

Provider Name: _____ Provider #: _____

Comments: _____

_____

_____

_____

_____

Signature: _____ Date: _____

APPENDIX VIII

OMB 0938-0279

1	2	3 PATIENT CONTROL NUMBER	4 TYPE OF BILL
	5 6C/BS PROV. NO.	6 FEDERAL TAX NO.	7 MEDICARE NO.	8 MEDICAID NO.	9

PATIENT'S LAST NAME | FIRST NAME | INITIAL | 11 PATIENT'S ADDRESS | CITY | STATE | ZIP

12 BIRTH DATE	13 SEX	14 MS	ADMISSION 15 DATE	16 HR	17 TYPE	18 SRC	19 A.H.	20 D.H.	21 STAT	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 COV. D.	24 N-C.D.	25 C-I.D.	26 L-R.D.	27

28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH

34

CONDITION CODES 35	36	37	38	39	BLOOD RECORD (PINTS) 40 PURN	41 REPL	42 NOT RP.	43 DED.	44 SP. PROG.	45

46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT
a							
b							

50 DESCRIPTION	51 R. CODE	52 S. UNITS	53 TOTAL CHARGES	54	55	56

57 PAYER	58 REL INFO	59 ASG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST. RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST. AMOUNT DUE
A							
B							
C							

ADMT DT. ▷ DISCH. DT. ▷ **DUE FROM PATIENT** ▶

65 INSURED'S NAME	66 SEX	67 P.REL	68 CERT.-SSN-HIC.-ID. NO.	69 GROUP NAME	70 INSURANCE GROUP NO.
A					
B					
C					

71 EID	72 ESC	73 EMPLOYER NAME.	74 EMPLOYEE ID.	75 EMPLOYER LOCATION

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS	77 PRIN. CODE	OTHER DIAGNOSES CODES 78	79	80	81

82 P.C.	83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS	84 PRINCIPAL PROCEDURE CD	DATE	85 OTHER PROCEDURE CD	DATE	86 OTHER PROCEDURE CD	DATE

PSRO UR DATA 87 APP. FROM	88 APP. THROUGH	89 GRC	91 TREATMENT AUTH	92 ATTENDING PHYSICIAN ID	93 OTHER PHYSICIAN ID

94 REMARKS

VERIFIED N-C STAY DATES FROM	THROUGH	FOR INTERMEDIARY USE ONLY PR PSC D		ADM. DIAG.

AMT. REIMBURSED	N-PYM. CD		APPROV. BY	DATE APPROV.

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

UB-82 HCFA-1450

PROVIDER REPRESENTATIVE X

96

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOME HEALTH SERVICES

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	CHARGES NOT COVERED	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
023104	DONALDSON R	3000000000	9883324-552-580	030192-033192	265.00	10.00	0.00	255.00	365
01 PS 4	PROC/REV 550	QTY 4		030192-033192	240.00	8.00		232.00	365
02 PS 4	PROC/REV 270	QTY 5		030192-033192	25.00	2.00		23.00	365

CLAIMS PAID IN THIS CATEGORY: 1 TOTAL BILLED: 265.00 TOTAL PAID: 255.00

APPENDIX IX

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOME HEALTH SERVICES

* DENIED CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	EOB
023104	JONES R	4000000000	9838348-552-010	030192-033192	60.00	
01 PS 4	PROC/REV 550	QTY 1		030192-033192	60.00	262

CLAIMS DENIED IN THIS CATEGORY: 1 TOTAL BILLED: 60.00

APPENDIX IX

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOME HEALTH SERVICES

* CLAIMS IN PROCESS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	EOB
571384	JOHNSON P	200000000	9883342-564-210	030192-033192	120.00	260
574632	MITCHELL J	400000000	9883347-575-240	030192-033192	240.00	260

CLAIMS PENDING IN THIS CATEGORY: 2 TOTAL BILLED: 360.00

APPENDIX IX

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOME HEALTH SERVICES

* RETURNED CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	EOB
324789	SMITH	5000000000	9883324-552-060	030192-033192	999

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 1

APPENDIX IX

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92
RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

SUMMARY OF BENEFITS PAID

CLAIMS PAYMENT SUMMARY CHECK NUMBER 3286364

	CLAIMS PAID/DENIED	CLAIMS PD AMT.	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	2	255.00	0.00	255.00	0.00	48.00
YEAR-TO-DATE TOTAL	36	1340.00	50.00	1290.00	0.00	1290.00

DESCRIPTION OF EXPLAINATION CODES LISTED ABOVE

061 PAID IN FULL BY MEDICAID
262 THE RECIPIENT IS NOT ELIGIBLE ON DATES OF SERVICE
260 ELIGIBILITY DETERMINATION IS BEING MADE
999 REQUIRED INFORMATION NOT PRESENT

APPENDIX IX

APPENDIX X

Rev. 5/92

PROVIDER INQUIRY FORM

EDS
P.O. Box 2009
Frankfort, KY 40602

Please remit **both** copies of the Inquiry Form to EDS.

1. Provider Number	3 Recipient Name (first, last)	
2. Provider Name and Address	4. Medical Assistance Number	
	5. Billed Amount	6. Claim Service Date
	7. RA Date	8. Internal Control Number
9. Provider's Message		

10. _____
Signature Date

Dear Provider:

_____ This claim has been resubmitted for possible payment.

_____ EDS can find no record of receipt of this claim as indicated above. Please resubmit.

_____ This claim paid on _____ in the amount of _____.

_____ This claim was denied on _____ with EOB code _____.

_____

_____ This claim denied on _____ with EOB 294 "Kenpac Recipient. Referring provider number is missing or is not the Kenpac primary physician/clinic number for the date(s) of service."

_____ This claim denied on _____ with EOB 295 "Kenpac Recipient. Billing and/or referring provider number is not the Kenpac primary physician/clinic for date(s) of service."

_____ This claim denied on _____ with EOB 281 "Recipient has other medical coverage. Bill other insurance first or attach documentation of denial from the insurance carrier."

_____ Aged claim. Please see attached documentation concerning services submitted past the 12 month filing limit.

Other: _____

_____

_____

_____

_____

_____

MAIL TO: EDS FEDERAL CORPORATION
P. O. BOX 2009
FRANKFORT, KY 40602

APPENDIX XI

ADJUSTMENT REQUEST FORM

1. Original Internal Control Number (I.C.N.)		EDS FEDERAL USE ONLY	
2. Recipient Name		3. Recipient Medicaid Number	
4. Provider Name/Number/Address		5. From Date Service	6. To Date Service
	7. Billed Amt.	8. Paid Amt.	9. R.A. Date

10. Please specify WHAT is to be adjusted on the claim.

11. Please specify REASON for the adjustment request or incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature

13. Date

EDSF USE ONLY--DO NOT WRITE BELOW THIS LINE

Field/Line:

New Data:

Previous Data:

Field/Line:

New Data:

Previous Data:

Other Actions/Remarks:

(Revised 1/92)

DEPARTMENT FOR MEDICAID SERVICES
DRUG PRE-AUTHORIZATION POLICIES AND PROCEDURES

INTRODUCTION

The purpose of the Drug Pre-Authorization Procedure shall be to provide Department for Medicaid Services (DMS) recipients with access to certain legend drugs not normally covered on the DMS Outpatient Drug List, under the condition that provision of the drug(s) in question is expected to make an otherwise inevitable hospitalization or higher level of care unnecessary. The requests shall be referred to the Program by physicians, pharmacists, and social workers. Determinations shall be made based on the merits of the individual request and information received.

To assist with determining the kinds of requests which shall be considered for pre-authorization, the following outline of criteria and procedures has been developed for your convenience.

I. DRUG PRE-AUTHORIZATION CRITERIA

A. Request Criteria

1. The requested drugs shall be used in lieu of hospitalization to maintain the patient on an outpatient basis or prevent a higher level of care.

2. The requested drug shall be a legend drug. The only exception shall be non-legend nutritional supplements when: 1) general pre-authorization criteria are met; 2) the patient's nutrition shall be maintained through the use of the nutritional product; and 3) the patient would require institutional care without the nutritional supplement.

3. The requested drug shall be used in accordance with standards and indications, and related conditions, approved by the Food and Drug Administration (FDA).

4. The requested drug shall not be considered for pre-authorization if it is currently classified by FDA as "less than effective" or "possibly effective" or if the labeler has not signed a rebate agreement with the Health Care Financing Administration (HCFA).

5. Drugs on the formulary shall be tried, when appropriate, with documentation of ineffectiveness prior to pre-authorization.

6. The Program shall not preauthorize the trial usage of a maintenance drug except when the drug has been tried for at least two (2) weeks with successful results prior to the request. In these cases, when all criteria shall be met, retroactive pre-authorization for two (2) weeks shall be considered in addition to the usual pre-authorization period.

B. Pre-Authorization of Therapeutic Categories

Any therapeutic category may be considered for pre-authorization in accordance with the diagnosis. However, all Program criteria and guidelines shall be met.

C. Guidelines For Specific Drug Categories

1. Analgesics

Requests for analgesics shall be approved for cancer, AIDS, spinal cord injury, and rehabilitation patients up to a period of six (6) months. A seven (7) day approval may be made following out-patient surgery.

2. Antibiotics

Requests for antibiotics shall be considered ONLY if culture and sensitivity tests have identified specific sensitivity or ONLY if drugs included on the Drug List have been tried unsuccessfully. However, if a course of treatment had been started while hospitalized, consideration shall be given to the request.

3. Anti-Inflammatory Drugs (NSAID's)

Request for anti-flammatory drugs shall not be pre-authorized unless drugs on the Drug List or NSAID certification list have been tried unsuccessfully.

4. Antitussives, "Cough Mixtures," Expectorants, Antihistamines

Request for "cough mixture" preparations such as expectorants and antitussives shall not be pre-authorized. Only specified antihistamines may be preauthorized if all other criteria have been met.

5. Chemotherapeutic Agents

Request for anti-neoplastic agents shall be considered for approved FDA indications.

6. Hypnotics and Sedatives

Requests for sedatives and hypnotics shall be considered only after covered antidepressant or antipsychotic drugs have been tried unsuccessfully and if hospitalization would be prevented. Also these requests shall be accompanied by an appropriate psychiatric diagnosis. Hypnotics and sedatives shall not be approved for more than two (2) weeks, unless there is a diagnosis of terminal cancer.

7. Maintenance-Type Drugs

Requests for maintenance-type drugs shall be considered only if the drugs have been tried for at least two (2) weeks with successful results prior to the request and related drugs on the formulary have been unsuccessful.

8. Non-Legend Drugs

Non-legend (over-the-counter) drugs shall be excluded from coverage under drug pre-authorization.

The only exceptions shall be non-legend nutritional supplements as noted in I. A. 2. above and nicotinic acid.

9. Ophthalmics and Topical Preparations

Requests for ophthalmics or topical preparations shall not be preauthorized unless related preparations included on the Drug List have been tried unsuccessfully, and a higher level of care would ensue without further medication.

10. Tranquilizers, Minor

Requests for minor tranquilizers shall be considered only for acute anxiety, alcohol or drug withdrawal (with a one (1) month limitation), cancer, seizure disorders, and quadriplegia/ paraplegia.

11. Ulcer Treatment Drugs, Legend

On the basis of ulcer symptoms, legend ulcer treatment drugs may be preauthorized if other applicable pre-authorization criteria are met.

12 Total Parenteral Nutrition

May be preauthorized if the need exists.

13. Transdermal Antihypertensive Medication

Transdermal antihypertensive medication may be pre-authorized without first prescribing oral forms when the prescriber certifies that the medication is certified for an elderly patient who is unable to follow directions in using oral forms of the medication.

D. Pharmacy Lock-In

The pharmacy originally selected by the recipient shall remain the provider during the period of the pre-authorization unless a valid reason for change exists.

E. PreAuthorization Period

The maximum period for which any drug shall be preauthorized shall be six (6) months. A request for renewal shall be considered if the need for the drug continues to exist. Extensions may be backdated if the dates do not interfere with already existing segments on the drug file.

F. Minimum Cost Requirement

Only those requests for oral, non-liquid drugs which cost $5.00 or more to the pharmacy for a month's supply or a course of treatment shall be considered for pre-authorization.

G. Routine Immunizations

Immunizations requested for routine health care shall not be approved. An underlying medical condition which would make the patient more susceptible to the disease must be present.

H. Exceptions to Existing Policy

The Commissioner for the Department for Medicaid Services, or his designate, may grant an exception to existing policy when sufficient documentation exists to override this policy. The request should be written, or followed up in writing, if necessary.

MAP-248
(Rev. 12/01)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Home Health Program

Agency Name_____Provider # _____

Agency Address_____

CERTIFICATION FOR DISPOSABLE MEDICAL SUPPLIES

Patient's Name_____MAID #_____

Address_____ Medicare #_____

_____ Birthdate_____

Other Insurance_____

Diagnosis_____

_____

_____

This is to certify that the following medical supplies are essential to meet the medical needs of this recipient.

(Indicate Directions for Use of the Supplies)_____

_____

_____

_____

_____

Anticipated Duration of Need:_____1-30 Days _____1-6 Months _____Lifetime _____Indefinite

I,_____ certify this patient requires the supplies listed above.
Physician's Signature

Address_____ License #_____Date_____

_____

Must be signed and dated by the physician every 6 months.

Technical Criteria for Reviewing Ancillary Services for Adults

February 2000 Edition

Cabinet for Health Services
Department for Medicaid Services
Division of Long Term Care
275 East Main Street 6W-B
Frankfort, Kentucky 40621

I. PHYSICAL THERAPY: REVIEW FOR BILLING AS ANCILLARY

A. **STANDARDS OF PRACTICE:** The review process shall employ the standards of practice developed by the American Physical Therapy Association.

B. Deficiency of function must be of a significant level that an ancillary clinician's expertise in designing or conducting a program in the presence of potential gain is documentable.

1. Therapeutic exercise

a. When exercising muscle or joint structure, the deficit requires a therapist's expertise to design, supervise, or conduct a program in which there is a need for functional or performance gain.
b. Progress is shown at predictable intervals.
c. Gradual progression is from passive to fully active range of motion per situation and reasonable goal.

Indication for Denial

a. Lacks documented detail of dysfunction or goal.
b. Goal seems unreasonable.
c. Stability of resident questioned.
d. Participation level a hindrance.
e. Plateaued, goal achieved, or needs only repetitive range of motion for nursing care plan.
f. Persistent flaccidity > 2—4 weeks in the focused area.

2. Cold Therapy

a. Pain or spasm reduction or adjustment to range of motion exercise (repeated cycles).
b. Trigger point use myofascial pain syndrome.
c. Spasticity.

Indication for Denial

a. Response gain is not demonstrable.
b. Performance is at nursing instructed level, and labile complex features.
c. Inappropriate use in a vascular compromised setting (or labile or poor blood pressure control).
d. Cold sensitivity disorder.

3. Low—Energy Laser

   a. Wound tissue healing.
   b. Pain management over trigger points.

   Indication for Denial

   a. Investigational.
   b. Effectiveness in rheumatoid arthritis questioned.

4. Transcutaneous Electric Nerve Stimulation (TENS)

   a. Post—operative incisional pain.
   b. Orthopedic analgesia acute or chronic, application to either trigger point or peripheral nerve.
   c. Chronic low back pain.
   d. Osteogenesis.
   e. Reflex sympathetic dystrophy (RSD).

   Indication for Denial

   a. Chronic radiculopathy pain.
   b. Cognitively impaired or unwilling to participate with schedule and safety factors.
   c. Unsafe application.
   d. Nursing is capable of managing (or resident can set—up, apply or control) after the initial evaluation of response or control setting is achieved.

5. Heat Therapy

   a. Active treatment of musculoskeletal mobility or pain problem as part of a therapist—driven treatment plan.
   b. In conjunction with an exercise regimen.

   Indication for Denial

   a. The active disorder is controlled, mostly for comfort.
   b. Complexity manageable by nursing.
   c. Resident is not responsive or is non-communicative.
   d. Ischemic limbs or other site or atrophic skin.

6. Ultrasound

   a. Joint contracture or scar tissue before friction massage, stretch, or range of motion (ROM) exercise (intensities and durations still need work), i.e., post—hip open reduction internal fixation.
   b. Reduce pain or muscle spasm.
   c. Trigger points.

   Indication for Denial

   a. Use in precautionary situations.
   b. Impaired sensitivity or ischemia.
   c. Questionable efficacy such as chronic herpes zoster, hemiplegic shoulder pain, fresh wound, or chronic pressure sore.

7. Hydrotherapy

   a. Facilitate assistive or resistive exercise.
   b. Removal of exudated or necrotic tissue.
   c. Reduce muscle spasm or pain.

   Indication for Denial

   a. General heat precautions.
   b. Treatment exposure using > 37 degrees centigrade in vascular impaired site.
   c. Absence of untoward effects or stable temperature tolerance and can be done by nursing staff.

8. Iontophoresis

   a. Antibiotic institution to avascular tissue.
   b. Medication for persistent post—surgical incision pain.
   c. Reduce inflammation or edema of musculosketetal (joints).

   Indication for Denial

   a. Anesthetic use (injection faster).
   b. Response lacking after reasonable interval.

9. Prosthesis

   a. Candidate has the capacity to use device.
   b. Candidate shows muscular strength, motor control, and range of motion adequate for gainful use.

   Indication for Denial

   a. Unteachable.
   b. Lacks items in 9-a and b.
   c. Poor wound healing.
   d. Other inappropriate conditions (such as bilateral, above-knee amputation over age 45, or below-elbow amputee or flail joint shoulder or elbow).
   e. Repetitive exercises that nursing care plan can accomplish pre—prothesis for stump shrinker use or prosthetic fitting.
   f. Repetitive use for distance or endurance only with level change having been achieved.
   g. Assisting routine care of equipment.
   h. Safety has been established so that the resident can perform trained exercise with supervision by nursing being the only need.

10. Electromyographic Biofeedback

   a. Spasticity or weakness as part of an acute cerebral vascular accident (CVA).
   b. Acute or chronic spinal cord injury.
   c. Multiple sclerosis with mild spasticity.

   Indication for Denial

   a. Absence of reasonable gain in the treatment plan time frame.
   b. Questionable effectiveness for the condition.
   c. Resident lacks voluntary control or motivation.

11. High Pressure Wound Irrigation

    a. Heavily contaminated wounds.

    Indication for Denial

    a. Clean proliferating wounds.
    b. Equipment or devices of questionable effectiveness or superiority to simpler devices.
    c. Nursing can provide equivalent service.

12. Hyperbaric Oxygen Wound Care

    a. Infected wounds or decubitus.
    b. Has reasonable circulation.

    Indication for Denial

    a. Advanced ischemic area.
    b. Potential for thromboembolism.
    c. Severe vasospasm.
    d. Lack of significant improvement in 4 weeks.

II. OCCUPATIONAL THERAPY: REVIEW FOR BILLING AS ANCILLARY

A. **STANDARDS OF PRACTICE:** The review process shall employ the standards of practice developed by the American Occupational Therapy Association.

B. Deficiency of function must be of a significant level that an ancillary clinician's expertise in designing or conducting a program in the presence of potential gain is documentable.

1. Therapeutic exercise

a. When exercising muscle or joint structure the deficit requires a therapist's expertise to design, supervise, or conduct a program in which there is a need for functional or performance gain.
b. Progress is shown at predictable intervals.
c. Gradual progression is from passive to fully active range of motion per situation and reasonable goal.

Indication for Denial

a. Lacks documented detail of dysfunction or goal.
b. Goal seems unreasonable.
c. Stability of the resident questioned.
d. Participation level is a hinderance.
e. Plateaued, goal achieved, or needs only repetitive ROM for nursing care plan.
f. Persistent flaccidity > 2—4 weeks focused area.

2. Shared Modalities for Physical Therapy

a. Heat therapy.
b. Cold therapy.
c. Prosthesis.
d. Electromyographic biofeedback.

Indication for Denial (see listings for Physical Therapy)

3. Functional Activities of Daily Living

a. Feed.
b. Dress.
c. Bathe.
d. Toileting.
e. Grooming.

f. Cognition.

Indication for Denial

a. The condition prevents the individual from engaging in the technique or use of the device.
b. Technique is reached, resident or nursing staff can maintain activities for endurance, distance or repetition.
c. Chronic condition, therefore potential useful gain is questioned or minimal.
d. Unable to advance or use more complex dexterity level due to cognitive limits..
e. Biofeedback use in the presence of a prominent disorder. speech, language use, cognition or volitional ability (inability to follow festural or verbal instruction.
f. Coma stimulation - effectiveness questionable

III. SPEECH THERAPY: REVIEW FOR BILLING AS ANCILLARY

A. **STANDARDS OF PRACTICE:** The review process will employ the preferred practice patterns developed by the American Speech—Language—Hearing Association.

B. Deficiency of function must be of a significant level that an ancillary clinician s expertise in designing or conducting a program in the presence of potential gain is documentable.

1. Treatment of Dysphagia (swallowing) Disorders

   a. Applicable diagnostic tests with confirmed abnormality (initial or progress recheck).
   b. Active teaching is appropriate for cognitive level (vs. delay till progress gain and provides alternative nutrition source).
   c. Uses specific postural, reflex facilitation, food placement, modified diet techniques with demonstrable progress.
   d. Prosthetic use.

   Indication for Denial

   a. Plateau, learned response, and repetitive exercise, reminders or prosthetics can be done by nursing as effectively.
   b. Confirmatory diagnostic test unavailable.
   c. Resident uncooperative or unreliable to safely use needed techniques.

2. Speech and Cognitive Disorders

   a. Tentative projected rehabilitation gain at the stage when cognitive level permits measurable change.
   b. Participation by resident required for repetitive or grouped exercises.
   c. Prosthetic training.
   d. Demonstrates there is no contributing significant auditory impairment.
   e. Use of nursing facility environment or staff to assist goals.

Indication for Denial

a. Inability to participate.
b. Plateau is reached in functional gain by measurable data or learned exercise and nursing can do repetitive technique.
c. Effectiveness of modality or participation level is in question.
d. Persisting active program beyond gain in condition having progressive deteriorating change or outlook (bilateral cerebral vascular accident, alzheimers).
e. Oral—nonverbal apraxia beyond 2 months.
f. Accompanying peripheral vision or hearing defects.

IV. OXYGEN THERAPY: REVIEW FOR MEDICAL NECESSITY

A. **STANDARDS OF PRACTICE:** The review process shall employ the Guidelines for Respiratory Care Services and Skilled Nursing Facilities developed jointly by the American Association of Respiratory Care and the American Health Care Association.

B. Technical abbreviations used in Item VII - Oxygen Therapy.
ABG - Areterial Blood Gases
AVF - Augmented Voltage Foot
O2 - Oxygen Level
paO2 - Partial Pressure of Oxygen
paCO2 - Partial Pressure of Carbon Dioxide
Oxygen Sats - Oxygen Saturation Levels
HCT - Hematocrit Level
mm Hg - Millimeters of Mercury

C. General Indicators.

1. Pa02 < 55 mm Hg or saturation < 88% while breathing ambient air.

2. Optimum medical management.

   a. Ancillary repiratory medications.
   b. Physiotherapy.
   c. Associated adverse conditions addressed.

3. PaO2 of 56-59 mm Hg or saturation of 91% in the presence of one or more of the following:

   a. Corpulmonale (p wave greater than 3 mm in standard leads II, III, or AVF).
   b. Right ventricular hypertrophy.
   c. Erythrocytosis (Hct > 56%).
   d. Reduced tissue oxygenation accompanied by neuropsych signs (i.e., tachycardia, tachypnea, dyspnea, cyanosis, diaphoresis chest pain or tightness, change in sensorium.

4. For that resident whose clinical condition prohibits evaluation of arterial oxygen saturation without supplemental oxygen:

   a. Oxygen saturation while on 02 < 92%.
   b. Pa02 < 60 mm Hg.

D. Continuous Oxygen

1. When hypoxemia criteria are established and met (found under general indicators) then continuous oxygen is appropriate.

2. Monitor clinical parameters (signs and symptoms associated with continuous oxygen needs).

3. Monitor results of oxygen therapy which measure functional improvement (i.e., ABF or oxygen Sats or improved symptoms).

E. Noncontinuous Oxygen

1. Documentation of clinically relevant hypoxemia related to exercise or nocturnal or sleeping even though "daytime resting" Pa02 or saturation may be adequate.

2. "As needed" (PRN) is generally not a valid reason to have available unless clinical documentation establishes hypoxemia and there exist circumstances why a person would not fit the category for continuous, exercise related, or sleep related.

F. Monitoring Condition

1. Acute use based on baseline Pa02/02 saturation and PaC02 in establishing initial oxygen dose.

2. The need for repeat use of ABG or oximetry depends upon the frequency the dose of oxygen is changed and/or the resident's altered clinical condition in response to therapy.

3. Use of ABG versus oximetry.

   a. Dependent on equipment available at facility or in area.
   b. Dependent upon the professionals available to secure arterial oxygen parameters and monitor or manage any subsequent condition.
   c. Dependent upon the arterial parameters needed.
   d. Oximetry is useful for non-hypercapneic persons as a guide to oxygen dose initation. It is simpler for nursing to utilize or log data. It is essentially nontraumatic for the resident (with few clinical complications). The data or results must be interpreted carefully per equipment variations applied (i.e., peripheral vascular disease). It may not correlate with Pa02 drawn in the same resident.

4. There are no criteria or resident requirements which fit all clinical situations to mandate ABG or oximetry testing for a stable resident. At least quarterly testing is advisable for the stable oxygen dependent condition. This is considered a reasonable interval to assess progress and establish continued need. More frequent may be warranted by physician judgment or changing clinical status. For the person with hypoxemia and hypercapnia establish regimen of oxygen or other treatment is suggested to be reassessed by ABG or oximetry every 1—2 months; again with exacerbation of illness of changing perameters of function closer monitoring intervals may be warranted.

G. Conservation of oxygen.

1. Devices in use that may be considered by treatment team or facility includes:

   a. Transtracheal oxygen delivery system.
   b. Reservoir mustache nasal prong.
   c. Reservoir pendant nasal system.

2. Adjusting up to 50% of the volume of oxygen delivered or used can be achieved with a decrease in overall expense but consideration has to be made for safety or complication in the transtracheal use. Also of note is the endurance or longevity factor associated with the pendant type product. It may not be as cost effective as the nasal prong as it is not as enduring.

V. RESPIRATORY THERAPY: REVIEW FOR BILLING AS ANCILLARY

A. **Standards of Practice:** The review process shall employ the Guidelines for Respiratory Care Services and Skilled Nursing Facilities developed jointly by the American Association of Respiratory Care and the American Health Care Association.

B. Technical abbreviations used in Item VIII — Respiratory Therapy.
FEVI — Forced Expired Volume after one second
FVC — Forced Vital Capacity
IPPB — Intermittent Positive Pressure Breathing
MDI — Metered Dose Inhalers
PFT — Pulmonary Function Tests

C. Indications.

1. Provide direct management of the following:

   a. Aerosolized drug delivery.
   b. Humidification.
   c. Secretion care management.
   d. Tracheostomy care.
   e. Osygenation changes (when possible in Conjunction with obtaining ABGs. or oximetry checks).

2. Teaching resident self treatment of the following:

   a. Aerosol.
   b. Breathing exercises.
   c. Cough guidelines.

3. Ongoing treatment requires the following:

   a. Specialty staff to assess response if new therapy.
   b. Specialty staff if respiratory therapy service is beyond usual nursing staff expertise (do the nurses provide the resident respiratory therapy on weekends when respiratory therapist is not available).
   c. If chronic clinical condition or nursing care plan therapy, documentation is necessary by the respiratory therapist and physician to support ongoing necessity of therapist versus nursing staff or resident administered therapy.

4. For a self administered system of therapy the following is required:

   a. Resident must demonstrate proper use of the equipment or medication delivery system.
   b. Resident delivery system monitored by nursing staff.
   c. Respiratory therapist intervention would be expected to drop when metered dose inhalers and nebulizers are utilized as resident or nursing staff can provide this therapy at the nursing care plan level.

5. The following situation may necessitate a respiratory therapist:

   a. Initial MDI or nebulization treatments may be performed by ancillary staff if no nursing staff is familiar with the mode of therapy. Should this occur, the ancillary respiratory therapist is responsible for providing instructions to nursing staff so that nursing staff can then provide MDI or nebulization treatments safely.

D. Aerosol Therapy.

1. Physician must order the medication utilized for the delivery system.

2. Mode of delivery or humidity needed may be determined by the respiratory therapist in the initial setting.

3. The simpler modalities are as effective and can be given in the absence of a respiratory therapist provided the facility staff are trained or comfortable or available to do this. Verify by physician order the acceptability of this process.

4. Metered dose inhalers (MDI) with or without spacers properly utilized were effective compared to nebulizers or IPPB (IPPB has been shown to be no more effective generally than MDI or nebulizers).

5. MDI should be attempted in bronchodilator therapy as simpler for nursing and residents to manage.

6. Nebulizer (compressed air driven apparatus) should be utilized when MDI is shown to be inadequate for the treatment of an individual clinical condition. It may also have to be utilized if a specific drug is not available via the MDI system.

7. Nebulizer therapy can be performed by the resident who is capable of reliable self care when trained by respiratory therapist or nursing staff. It can also be performed with safety by facility staff. The need for a respiratory therapist should be evident in charting. It is reasonable to utilize the respiratory therapist initially to verify resident response to nebulizer therapy but once considered stable or nursing care plan then the facility staff or resident should assume nebulizer therapy responsibility.

8. IPPB (intermittent positive pressure breathing) has principally been replaced by MDI or nebulizer therapy as the acceptable delivery system. It is no more effective than other equipment. If utilized documentation should exist why other simpler and potentially less complication associated mode care not utilized. This therapy would potentially require a respiratory therapist beyond the initial phase of administration.

9. The use of inhalers and bronchodilator therapies should always be supported by persistent symptoms, physical findings as well as PFT (Pulmonary Function Test). This information should be found in the respiratory therapist's notes. Usually documented is impairment of airway or lungs function and should be considered greater than "mild" dysfunction. Criteria for PFT which indicate moderate obstruction follow:

    a. FEV1 51—59% predicted.
    b. FEV1/FVC 41—59% predicted.
    c. Clinical evidence that there is a reversible component to support use of an aerosol bronchodilator.

10. The frequency of treatment (MDI or nebulizers) should be reasonable for the illness or clinical presentation. Generally, aerosolized bronchodilator are given at intervals that correspond to duration of effect of the drug or aerosol treatment. (Monitor significantly reduced PRN schedules as there could be question to the need for the drug in this form of delivery frequency).

E. Monitoring Therapy.

1. It is the physician's responsibility to assess the plan of treatment and document the resolution if short term therapy. In the event of a chronic diagnosis the physician must document the reasonable nature of ongoing therapy.

2. In the event of long term treatment the following information should be available:

   a. Annual Pulmonary Function Test (PFT) should be available.
   b. Peak flow rates—to serve as intermittent indicators to be determined by the attending physician or respiratory therapist.

3. Appropriateness of therapy should be questioned in the following situations:

   a. Chest physiotherapy or use of mucolytic aerosols when no secretions are evident after treatment course is "completed."
   b. Aerosol therapy for interstitial lung disease as primary diagnosis for treatment initiation.
   c. Aerosol therapy when irreversible airflow obstruction exists.

Technical Criteria for Reviewing Ancillary Services for Pediatrics

April 2000 Edition

Cabinet for Health Services
Department for Medicaid Services
Division of Long Term Care
275 East Main Street 6W-B
Frankfort, Kentucky 40621

I. PHYSICAL THERAPY: REVIEW FOR BILLING AS AN ANCILLARY SERVICE- PEDIATRICS

A. **Standards of Practice:** The review process shall employ the standards of practice by the American Physical Therapy Association.

B. Deficiency of function must be of significant level that an ancillary clinician's expertise in designing or conducting program in presence of potential gain is documentable.

1. Therapeutic exercise/gross motor development program.

   a. Exercises are designed to utilize neuro developmental techniques, reflex integration, and perceptual-sensory motor integration to assist to reach the maximum potential possible. The Therapist's expertise is required to design, supervise or conduct a program in which there is a need for developmental or functional gain.
   b. Progress is demonstrated at predictable intervals.

   Indication for Denial

   a. Medically unstable.
   b. Goal seems unreasonable.
   c. Participation level questioned.
   d. Plateaued or achieved goals..
   e. Lacks documentation.

2. Chest Therapy-when respiratory therapy is not available.

   Postural drainage, including positioning to loosen secretions and promote drainage is within the training of the Physical Therapist. This is addressed with the bed fast, non-ambulatory or resident with pneumonia.

   Indication for Denial

   a. In-house Respiratory therapist.
   b. Managed by nursing/caregiver.
   c. Condition clinically stable and manageable by nursing/caregiver.

3. Equipment and/or orthopedic appliances assessed, fitted, adjusted and monitored. The pediatric resident utilizes equipment throughout his/her lifetime.

   a. Modify or monitor wheelchairs.
   b. Upon M.D. prescription, order, modify, monitor orthotic appliances. Work to train care givers and residents use of appliances. This includes, but is not limited to, braces, walkers, crutches, canes, oyster shells and back braces.

   Indication for Denial

   a. Unteachable.
   b. Repetitive use for distance or endurance.
   c. Resident can perform trained excersises.
   d. Nursing can monitor fit.
   e. Nursing can monitor maintenance of equipment of minor deficiencies/repairs.

4. Assessment to provide individualized, detailed documentation of the function of a particular child. This is generally performed at 6-12 month intervals or when change is indicated. Assessment may include, but is not limited to:

   a. Postural reflex integration.
   b. Status of sensory, motor, neuro motor and musculoskeletal systems.
   c. Perceptual motor development.
   d. Joint range of motion.
   e. Analysis of functional independence.
   f. Postural deviations.
   g. Gait analysis.
   h. Developmental level, including gross and fine motors.
   I. Adaptive equipment needs.
   j. Resident's and/or family needs.

   Indication for Denial

   a. Resident medically unstable.
   b. Lacks developmental maturation changes to justify reassessment.
   c. Lacks potential for gain.

5. Consultation and caregiver instructions are required as changes occur with the pediatric resident. Consultation to staff, such as nursing, respiratory therapy, classroom personnel, is needed to assist in the overall care. This consultation is needed in order to utilize the skills of the therapist for instruction and ongoing programming. This could include, but not limited to instruction for:

   a. Application of orthopedic appliances.
   b. Use of adaptive equipment
   c. Positioning.
   d. Routine exercises.
   e. Routine gait training.

   Indication for Denial

   a. Resident not able to participate medically.
   b. Lacks changes (regression or improvement) to justify consultation.
   c. Lacks potential for gain.
   d. Nursing/caregiver can provide modification.

6. Cold Therapy

   a. Pain or spasm reduction or adjustment to range of motion exercise (repeated cycles).
   b. Trigger point use myofascial pain syndrome.
   c. Spasticity.

   Indication for Denial

   a. Response gain is not demonstrable.
   b. Performance at nursing care plan level-routine program with no complex features.
   c. Inappropriate use in vascular compromised setting (or labile or poor blood pressure control).
   d. Cold sensitivity disorder.

7. Low-Energy Laser.

    a. Wound tissue healing.
    b. Pain management over trigger points.

    Indication for Denial

    a. Investigational.
    b. Efficacy in rheumatoid arthritis questioned.

8. Transcutaneous Electric Nerve Stimulation (TENS).

    a. Post-operative incisional pain.
    b. Orthopedic analgesia acute or chronic, apply to either trigger point or peripheral nerve.
    c. Low back pain chronic.
    d. Osteogenesis.
    e. Reflex sympathetic dystrophy (RSD).

    Indication for Denial

    a. Chronic radiculopathy pain.
    b. Cognitively impaired or unwilling to participate, with schedule and safety factors.
    c. Unsafe application.
    d. Nursing capable of managing (or resident can set-up, apply or control) after initial evaluation of response or control setting achieve.

9. Heat Therapy.

    a. Treatment actively of musculoskeletal mobility or pain problems as part of a therapist-driven treatment plan.
    b. In conjunction with exercise regimen.

    Indication for Denial

    a. Active disorder controlled, mostly comfort.
    b. Complexity manageable by nursing.
    c. Resident not responsive or non-communicable.
    d. Ischemic limbs or other site or atrophic skin.

10. Ultrasound.

    a. Joint contracture or scar tissue before friction massage, stretch, or range of motion (ROM) exercise (intensities and durations still need work), i.e. post-hip open reduction internal fixation.
    b. Reduce pain or muscle spasms.
    c. Trigger points.

    Indication for Denial

    a. Use in precautionary situations.
    b. Impaired sensitivity or ischemia.
    c. Questionable efficacy such as chronic herpes zoster, hemiplegic shoulder pain, fresh wound, or chronic pressure sores.

11. Hydrotherapy.

    a. Facilitate assistive or resistive exercise.
    b. Removal exudate or necrotic tissue.
    c. Reduce muscle spasm or pain.

    Indication for Denial

    a. General heat precautions.
    b. Treatment exposure using >37 degrees centigrade vascular impaired site.
    c. Absence untoward effects or stable temperature tolerance and can be done by nursing staff.

12. Iontophoresis

    a. Antibiotic institution to avascular tissue.
    b. Medication for persistent post-surgical incision pain.
    c. Reduce inflammation or edema musculoskeletal (joints).

    Indication for Denial

    a. Anesthetic use (injection faster).
    b. Response lacking reasonable interval.

13. Prosthesis.
    a. Resident has capacity to use device.
    b. Resident shows muscular strength, motor control, and range of motion adequate for gainful use.

Indication for Denial

    a. Unteachable
    b. Lacks above features.
    c. Poor wound healing.
    d. Other inappropriate conditions (such as bilateral above knee amputation over age of 45, or below elbow amputee and flail shoulder or elbow).
    e. Repetitive exercises, and/or use of pre-prothesis stump shinker prior to prosthetic fitting can be carried as part of the nursing care plan.
    f. Repetitive use for distance or endurance only and level change has been achieved.
    g. Assisting routine care of equipment.
    h. Resident can perform trained exercises with supervision by nursing.

14. Electromyographic Biofeedback.

    a. Spasticity or weakness as part of acute cerebral vascular accident (CVA).
    b. Acute or chronic spinal cord injury.
    c. Multiple sclerosis with mild spasticity.

Indication for Denial

    a. Absence of reasonable gain in treatment plan time frame.
    b. Conditions of questionable effectiveness.
    c. Resident lacks voluntary control or motivation.

15. High Pressure Wound Irrigation.

    a. Heavily contaminated wounds.

    Indication for Denial

    a. Clean proliferating wounds.
    b. Equipment or devices of questionable efficacy of superiority to simpler devices.
    c. Nursing can provide equivalent service.

16. Hyperbaric Oxygen Wound Care.

    a. Infected wounds or decubitus.
    b. Has reasonable circulation.

    Indication for Denial

    a. Advanced ischemic area.
    b. Potential for thromboembolism.
    c. Severe vasospasm.
    d. Lack of significant improvement in 4 weeks.

II. OCCUPATIONAL THERAPY: REVIEW FOR BILLING AS AN ANCILLARY SERVICE-PEDIATRICS

A. **Standards of Practice:** The review process shall employ the standards of practice developed by the American Occupational Therapy Association.

B. Deficiency of function must be of significant level that an ancillary clinician's expertise in designing or conducting the program in the presence of potential gain is. documentable. Uniform terminology of Occupational Therapy developed by the American Occupational Therapy Association shall be used to define deficiency of function.

1. Therapeutic activities shall address appropriate Occupational Therapy performance areas of:

   Activities of daily living.
   Work activities.
   Play or leisure activities.

   Treatment in each performance area shall address specific performance components. These performance components consist of

   Sensory Motor Skills.
   Cognitive Skills.
   Psychological Skills.

   (Please refer to attached copy of uniform terminblogy for Occupational Therapy definitions of performance areas and performance components.)

   a. Implementation of therapeutic activities requires a therapists' expertise to design, supervise, or conduct a program in which there is a need for functional or performance gain.
   b. Progress is shown at predictable interval for remediation of dysfunction where appropriate.
   c. Compensatory and prevention intervention models are also utilized in treatment of individuals with chronic conditions and developmental disabilities. This may include adaptive equipment, technology, graded assistance, and task modification. Documentation of outcomes shall reflect progress in function in performance areas and performance components.

Indication of Denial

a. Lacks documented details of dysfunction or goal.
b. Stability of resident questioned.
c. Participation level a hindrance.
d. Unreasonable goal.
e. Plateaued, goal achieved, or needs only repetitive ROM, ADL coaching, or ustimulationn environment as by nursing care plan.
f. Adaptive equipment lacks usable functionality.
g. Nursing/caregiver can provide preventativelcompensatory techniques for ongoing application.

2. Activities of Daily Living

a. Grooming.
b. Oral Hygiene.
c. Toilet Hygiene.
d. Dressing.
e. Feeding and eating.
f. Medication routine.
g. Socialization.
h. Functional mobility

Highest level of function shall be consistent with developmental levels. Prerequisite' skills in identified performance areas shall be targeted and progress documented, including use of compensatory strategies and adaptive equipment When a plateau is reached, periodic re-evaluation are allowed and the ancillary clinician may resume treatment program if resident shows documented changes in function in performance area and performance components. Updating and progressing the activities of daily living program requires the expertise of the ancillary clinician and periodic program update with care-giver instruction are allowable.

Indication of Denial

a. Condition prevents engaging techniques or use of device.
b. Technique learned, resident or nursing staff can carry-out routinely.
c. Chronic condition limits functional gain-documentation shows failure of prescribed technique over reasonable time span.
d. Unable to advance or use more complex dexterity level due to cognitive limits-documentation shows failure of compensatory strategies over reasonable time span.

3. Splinting and fabrication/prescription for adaptive equipment/environments.

a. Fabrication and fitting of splints and adaptive devices restore function in neuromuscular and/or motor performance components to support highest practicable level of function as part of intervention plan.
b. Therapist shall document prescribed use of splints or devices and instruct caregiver
c. Therapist shall monitor, fit and repair splint or device and periodically make necessary modifications for fit, safety and changes in function.
d. Design of adaptive equipment and environment to improve function in performance areas and specified performance components that requires expertise of an ancillary clinician. Include safety devices and restraint alternatives in keeping with OBRA guidelines for restraint free environments.

Indication for Denial

a. Documentation does not support need.
b. Use of splint/device/environment incorporated into routine and nursing care plan (re-evaluation and modification by Occupational Therapist are allowable when changes in function occur.)

4. Consultation and Care-Givers Instruction
Consultation with care-givers shall be provided to establish consistency with nursing care plan and to prepare for discharge.

a. Clinically relevant deficiencies are present.
b. Potential gain is evident
c. The resident demonstrates developmental maturation changes that need ancillary OT input.

III. SPEECH THERAPY: REVIEW FOR BILLING AS AN ANCILLARY SERVICE-PEDIATRICS

A. Preferred practice patterns for professions of Speech-language Pathology and Audiology shall be those developed by the American Speech and Hearing Association.

B. Deficiency of function must be of significant level that an ancillary clinician's expertise in designing or conducting program in presence of potential gain, or, as a preventative measure, is documentable.

1. Speech (articulation, fluency, voice), Language and Cognitive Disorders.

   a. Utilization of standardized testing measures.
   b. Treatment is conducted to achieve improved, altered, augmented, or compensated speech, language and cognitive communication behaviors or processes.
   c. Treatment may include prerequisite skill training which includes, but not limited to cooing, respiratory support for vocalization, oral stimulation, vocal turn taking, inflection, object permanence, cause and effect knowledge, problem-solving, gesturelsign.
   d. Prosthetic/adaptive device training (e.g. speaking valve, adaptive switch, adapted toys, etc.)
   e. Equipment maintenance at interval consistent with:

      1. Physical and/or developmental change.
      2. New equipment problem beyond nursing/caregiver expertise.

Indication for Denial

a. Standardized and nonstandardized measures reveal age appropriate speech-language and cognitive skills.
b. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and the annual speech-language evaluation.

2. Oral pharyngeal function (dysphagia) and related disorders.

    a. Applicable diagnostic testing with confirmed abnormality.
    b. The absence of, or restricted oral presentation of food and/or liquids.
    c. Strategies that alter behavior (e.g., posture, rate, learned airway protection measures, method of intake, prosthetic use, etc.)
    d. Modification of swallowing activity in coordination with respiratory or alternation of bolus characteristics (e.g. volume, consistency).
    e. Equipment maintenance at interval consistent with:

        1. Physical and/or developmental change.
        2. New equipment problem beyond nursing/caregiver expertise.

    Indication for Denial

    a. Standardized tests, observations, instrumental diagnostic procedures, structural assessment and functional assessment reveal normal parameters of the swallow system and other oral pharyngeal functions.
    b. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and the annual speech-language evaluation.
    c. Lack new equipment problem.
    d. Nursing/caregiver can perform maintenance/repair.
    e. Lack of nursing/caregiver training.

3. Augmentative and Alternative Communication (AAC) Systems.

    a. Training of prerequisite skills for AAC includes, but not limited to visual attention, visual tracking, choice making activities, cause and effect knowledge and anticipation of outcome.
    b. Determination of the MC intervention program (assessment).
    c. Selection and the development of an effective AAC system.
    d. Service implementation and system integration into the natural environment. Includes care-giver training.
    e. Follow-up and ongoing evaluation.
    f. Equipment maintenance at interval consistent with:

        1. Physical and/or developmental change.
        2. New equipment problem beyond nursing/caregiver expertise.

Indication for Denial

a. Standardized and nonstandardized measures reveal age appropriate speech-language skills, utilizing AAC.
b. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and annual speech-language evaluation.
c. Lack new equipment problem.
d. Nursing/caregiver can perform maintenance repair.
e. Lack of nursing/caregiver training.

4. Aural Habilitation/Rehabilitation.

a. Comprehension and production of language in oral, augmentative, signed or written modalities.
b. Speech and voice production.
c. Auditory training.
d. Speech reading.

Indication for Denial

a. Audiological assessment reveals adequate hearing acuity.
b. Standardized and nonstandardized measures reveal age appropriated speech-language and cognitive skills. U,
c. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and annual speech language evaluation.
d. Lack new equipment problem.
e. Nursing/caregiver can perform maintenancelrepair.
f. Lack of nursinglcaregiver training.

5. Consultation and care Giver Instruction

a. Consultation and caregiver instructions are required as changes occur with the pediatric resident. Consultation to staff, such as nursing, respiratory therapy, classroom personnel, is needed to assist in the overall care. This consultation is needed in order to utilize the skills of the therapist for instruction and ongoing programming, taking into consideration:

1. Clinically relevant deficiencies.
2. Potential gain.
3. Demonstrable developmental maturation changes that require ancillary ST input.

Indication for Denial

a. Resident not able to participate medically.

IV. OXYGEN THERAPY: REVIEW FOR MEDICAL NECESSITY

A. Standards of Practice. The review process shall employ the Guidelines for Respiratory Care Services and Skilled Nursing Facilities developed jointly by the American Association of Respiratory Care and the American Health Care Association. The pediatric criteria not found here shall be based on age appropriate parameters obtained from current textbook baselines.

Technical abbreviations used in item IV-Oxygen Therapy:

1. ABG-Arterial Blood Gases;
2. AVF-Augmented Voltage Foot;
3. 02- Oxygen Level;
4. PaO_2 -Partial Pressure for Oxygen;
5. $PaCO_2$ -Partial Pressure of Carbon Dioxide;
6. Oxygen Sats-Oxygen saturation levels;
7. HCT-Hematocrit Level; and
8. $_{mm}$ Hg- Millimeters of Mercury

C. General Indicators

1. Oxygen saturation < 93% or PaO_2 <65 $_{mm}$ Hg while breathing room air.

2. Optimum medical management.

   a. Ancillary respiratory medications.
   b. Physiotherapy.
   c. Associated adverse conditions addressed.

3. PaO2 of 56-59 mm Hg or saturation of 91 percent in the presence of one or more of the following:

   a. Cor pulmonale (p wave greater than 3mm in standard leads II, III, or AVF).
   b. Right ventricular hypertrophy.
   c. Erythrocytosis (Hct >56 percent).
   d. Reduced tissue oxygenation accompanied by neuropsych signs (i.e., tachycardia, tachypnea, dysnea, cyanosis, diaphoresis chest pain or tightness, change in sensorium.)

4. For that resident whose clinical condition prohibits evaluation of arterial oxygen saturation without supplemental oxygen:

   a. Oxygen saturation <95% or PaO_2 <65 $_{mm}$ Hg while breathing oxygen. Monitor functional improvement resulting from oxygen therapy (e.g., oxygen saturation, PaO_2, symptomatic improvement.

D. Continuous Oxygen

1. When hypoxemia criteria are established and met (found under general indicators) then continuous oxygen is appropriate.

2. Monitor clinical parameters (signs and symptoms associated with continuous oxygen needs).

3. Monitor results of oxygen therapy which measure functional improvement (i.e., ABG or oxygen sats or improved symptoms).

E. Noncontinuos Oxygen

1. Documentation of clinically relevant hypoxemia related to exercise or nocturnal or sleeping even though "daytime resting" PaO2 or saturation may be adequate.

2. "As needed" (PRN) is generally not a valid reason to have oxygen available unless clinical documentation establishes hypoxemia and there exist circumstances why the person would not fit the category for continuous oxygen or, exercise related or sleep related non-continuos oxygen. An exception is made for brittle pediatric residents who have a significantly decreased PaO_2 with feeding, communication, or crying.

F. Monitoring Condition

1. Acute use based on baseline PaO_2 or O_2 saturation and $PaCO_2$ in establishing initial oxygen dose.

2. The need for repeat use of ABG or oximetry depends upon the frequency the dose of oxygen is changes or changes in the resident's clinical condition in response to therapy.

3. Use of ABG versus oximetry.

   a. Dependent on equipment available at facility or in area.
   b. Dependent upon the professionals available to secure arterial oxygen parameters and monitor or manage any subsequent conditions.
   c. Dependent upon the arterial parameter needed.
   d. Oximetry is useful for non-hypercapnic persons as a guide to oxygen dose initiation. It is simpler for nursing to utilize or log data. It is essentially non-traumatic for the resident (with few clinical complications). The data or results must be interpreted carefully per equipment variations applied (i.e., peripheral vascular disease). It may not correlate with $PaCO_2$ drawn in the same resident.

4. There are no criteria or resident requirements which fit all clinical situations to mandate ABG or oximetry testing for a stable resident. At least quarterly testing is advisable for the stable, oxygen dependent condition. This is considered a reasonable interval to assess progress and established continued need. More frequent testing may be warranted by physician judgment or changing clinical status. For the person with hypoxemia and hypercapnia, the established regimen of oxygen or other treatment is suggested to be reassessed by ABG or oximetry every 1 to 2 months. With exacerbation or illness of changing perimeters of function, closer monitoring intervals may be warranted.

G. Conservation of oxygen.

1. Devices in use that may be considered by the treatment team or facility includes:

   a. Transtracheal oxygen delivery system.
   b. Reservoir mustache nasal prong.
   c. Reservoir pendant nasal system.

2. Adjusting up to 50 percent of the volume of oxygen delivered or used can be achieved with a decrease in overall expense but consideration has to be made for safety or complication in the transtracheal use. Also of note is the endurance or longevity factor associated with the pendant type product. It may not be as cost-effective as the nasal prong as it is not as enduring.

V. RESPIRATORY THERAPY: REVIEW FOR BILLING AS AN ANCILLARY PEDIATRICS

A. Standards of Practice. The review process shall employ the Guidelines for Respiratory Care Services and Skilled Nursing Facilities developed jointly by the American Association of Respiratory Care and the American Health Care Association. The pediatric criteria not found here shall be based on age appropriate parameters obtained from current textbook baselines.

B. Technical abbreviations used in Item VIII-Respiratory Therapy.
FEVI-Forced Expired Volume after one second
FVC-Forced Vital Capacity
IPPB- Intermittent Positive. Pressure Breathing
MDI- Metered Dose Inhalers
PFT-Pulmonary Function Tests

C. Indications.

1. Provide direct management of the following:

   a. Aersolized drug delivery.
   b. Humidificaiton.
   c. Secretion care management.
   d. Tracheostomy care.
   e. Oxygenation changes (when possible in conjunction with obtaining ABG's or oximetry checks).

2. Teaching resident self treatment of following:
   (In pediatric care patient education is dependent on age and severity of the physical and mental disabilities of the child):

   a. Aerosol.
   b. Breathing exercises.
   c. Cough guidelines.

3. Ongoing treatment requires the following:

   a. Specialty staff to assess response if new therapy.
   b. Specialty staff if respiratory therapy service is beyond usual nursing staff expertise (do the nurses provide the resident respiratory therapist on weekends when respiratory therapist is not available).
   c. If chronic clinical condition or nursing care plan therapy, documentation is necessary by the respiratory therapist and physician to support ongoing necessity of therapist versus nursing staff or resident administered therapy.

4. For self administered system of therapy the following is required:

   a. Resident must demonstrate proper use of the equipment or medication delivery system.
   b. Resident delivery system monitored by nursing staff.
   c. Respiratory therepaist intervention would be expected to drop when metered dose inhalers and nebulizers are utilized as resident or nursing staff can provide this therapy at the nursing care plan level.

5. The following situation may necessitate a respiratory therapist:

   a. Initial MDI or nebulization treatments may be performed by ancillary staff if no nursing staff is familiar with the mode of therapy. Should this occur, the ancillary respiratory therapist is responsible for providing instruction to nursing staff so that nursing staff can then provide MDI or nebulization treatments safely.
   b. If the pediatric patient has an acute or ongoing unstable pulmonary problem, including deterioration in status, complex respiratory care needs, frequent monitoring, weaning of modalities, complications of primary disease or therapies.

c. Aerosol Therapy.

(1) Physician must order the medication utilized for the delivery system.
(2) Mode of delivery or humidity needed may be determined by the respiratory therapist in the initial setting.
(3) The simpler modalities are as effective and can be given in the absence respiratory therapist provided the facility staff are trained and comfortable or available to do this. Verify by physician order the acceptability of this process.
(4) Metered does inhalers (MDI) with or without spacers properly utilized.
(5) MDI (if child is on dosage compatible) should be attempted in bronchodilatior therapy as simpler for nursing and residents to manage.
(6) Nebulizer (compressed air driven apparatus) should be utilized when MDI is shown to be inadequate for the treatment of an individual clinical condition. It may also have to be utilized if a specific drug is not available via the MDI system.
(7) Nebulizer therapy can be performed safely by facility staff. Nebulizer therapy can also be performed by the resident who is capable of reliable self care when trained by respiratory therapist or nursing staff. It is reasonable to utilize the respiratory therapist initially to verify resident reponse to nebulizer theapy but once considered stable or nursing care plan then the facility staff ro resident should assume nebulizer therapy responsibility.
(8) IPPB (intermittent positive pressure breathing) has principally been replaced by MDI or nebulizer therapy as the acceptable delivery system. It is no more effective than other equipment. If utilized documentation should exist why other simpler and potentially less complication associated mode care not utilized. This therapy would potentially required a respiratory therapist beyond the initial phase of administration.
(9) The use of inhalers and bronchodilator therapy should always be supported by persistent symptoms and physical findings as well as PFT (Pulmonary Function Test) if applicable. This information should be found in the respiratory therapist's notes. Usually documented is impairment of airway or lungs function and should be considered greater than "mild" dysfunction. Criteria based on PFTs is not usually feasible in the pediatric population due to the inability to follow commands for inspiration, expiration or sustained

apnea. PFT criteria is most applicable to adults and older, cooperative children. PFT criteria for continued therapy is not required for children who are unable to perform PFT accurately and who require continued therapy because of the continued respiratory problems.

(10) The frequency of treatment (MDI or nebulizers) should be reasonable for the illness or clinical presentation. Generally, aerosolized bronchodilator are given at intervals that correspond to duration of effect of the drug or aerosol treatment. (Monitor significantly reduced PRN schedules as there could be question to the need for the drug in this form of delivery frequency). Children, however, may have respiratory problems which are very episodic and presence of sporadically used respiratory treatments may often be appropriate treatment for short-lived, episodic, respiratory problems.

d. Monitoring Therapy.

1. It is the physician's responsibility to assess the plan of treatment and document the resolution if short term therapy. In the event of a chronic diagnosis the physician must document the reasonable nature of ongoing therapy.
2. In the event of long term treatment the following information should be available:

   a. Annual Pulmonary Function Test (PFT) should be available.
   b. Peak flow rates-to serve as intermittent indicators to be determined by the attending physician or respiratory therapist.
   c. If accurate pulmonary function testing or peak flow rates are not possible because the pediatric patient is unable to perform them, documentation of the need for long term therapy can be made on the basis of the frequency of acute episodes during the previous year as described in the care record.

D. Respiratory staffing of neonatal and young children.

1. Older children or adolescents with pulmonary disorders amenable to active respiratory treatment will require the intervention and monitoring of a respiratory therapistin most situations. This is principally for the purspose of addressing changing oxygenation needs and secretions clearing problems

generally found in these residents.

2. If a plateau has been indicated via documentation then one could consider transferring care to the facility staff for the uncomplicated, stable lung disorder. This could encompass the following care needs:

   a. Aerosal therapy.
   b. Routine trach care.
   c. Nursing care plan oxygen administration.

3. Nursing care plan service or plateau should be supported by documentation in the ongoing nursing assessment and the respiratory therapist's notes. The potential for changing to facility staff provided or supervised therapy administration or delivery systems exists if resident is stable or nursing care plan with chronic condition. This care provision change should be considered less complex, less costly and should not adversely affect the efficacy of the treatment.

DIRTY

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APPENDIX XIII

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

Home Health Program

Agency Name _____ Vendor # _____

Agency Address _____

CERTIFICATION FOR DISPOSABLE MEDICAL SUPPLIES

Patient's Name _____ MAID # _____

Address _____ Medicare # _____

_____ Birthdate _____

Other Insurance _____

Diagnosis _____

_____

_____

...is to certify that the following medical supplies are essential to meet the medical needs of this recipient.

Indicate Directions for Use of the Supplies) _____

_____

_____

_____

_____

Anticipated Duration of Need: _____ 0-30 days _____ 1-6 months

_____ Lifetime _____ Indefinite

_____ _____

Date Physician's Signature

_____

Address

_____

License #

ust be signed and dated by the physician.